California State Auditor

BUREAU OF STATE AUDITS

California's Workers' Compensation Program:

Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis

January 2004
2003-108.2

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CALIFORNIA STATE AUDITOR

ELAINE M. HOWLE
STATE AUDITOR

STEVEN M. HENDRICKSON
CHIEF DEPUTY STATE AUDITOR

January 27, 2004 2003-108.2

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the medical costs related to the workers' compensation insurance system and the extent to which the payment structure has resulted in unacceptably high reimbursement rates.

This report concludes that reforms to the workers' compensation medical payment system mandated by Chapter 639, Statutes of 2003, effective January 1, 2004, will produce substantial savings in the form of lower payments for nonhospital outpatient surgical facilities (surgical centers) and pharmaceuticals if those reforms are carefully implemented. Our analysis indicates that had similar reforms been in place during 2002, the State Compensation Insurance Fund (State Fund) could have saved anywhere from $7.8 million to $8.9 million of the amount it paid to surgical centers for facility fees. These savings represent about 54 percent to 61 percent (with a midpoint of $8.4 million, or 58 percent) of the payments we were able to analyze. We also calculated that State Fund could have saved another $18 million (or about 24 percent) on the amount it spent on prescription drugs. These conclusions are based on our review of State Fund payments to surgical centers and payments for pharmaceuticals with sufficient detail to allow for analysis. Certain features of the data contained in State Fund's medical bill review file limited our review to $14.5 million of the $43 million in identifiable payments to surgical centers made in 2002. Our analysis was limited because data entered into State Fund's medical bill review file were often incomplete or summarized without retaining unique identifiers, and the database design prevented detailed analysis. Based on our analysis of State Fund's data and the results of an insurer survey conducted by the Division of Workers' Compensation (division), the condition of State Fund's and other insurers' data presents challenges to the division's efforts to develop a comprehensive database of workers' compensation medical information that will allow it to monitor the workers' compensation insurance system and measure the effects of policy changes on the system's performance and costs.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

CONTENTS

Summary 1

Introduction 9

Chapter 1

Changes to the State's Workers' Compensation Medical Payment System Will Cause Payments for Outpatient Surgical Facility Services and Prescription Drugs to Drop Sharply 19

Chapter 2

Savings Depend on the Careful Implementation of the Medical Payment Fee Schedules and Monitoring of the Medical Payment System 35

Recommendations 41

Appendix A

State Fund Payments to Surgical Centers During 2002 Compared to 120 Percent of Medicare's Ambulatory Surgical Center Fee Schedule 43

Appendix B

Results of the Division of Workers' Compensation Survey of Insurance Companies to Determine Available Medical Data 47

Responses to the Audit

State Compensation Insurance Fund 51

California State Auditor's Comment on the Response From the State Compensation Insurance Fund 53

California Labor and Workforce Development Agency 55

SUMMARY

Audit Highlights . . .

Our analysis of medical claims payment data from the State Compensation Insurance Fund (State Fund) to determine the extent to which new reforms would have produced savings in workers' compensation medical costs had they been in effect during 2002 revealed that:

- ☑ ***Although data limitations constrained our analysis, the data we were able to analyze showed that the recent reforms would produce savings in the form of lower payments for outpatient surgical facilities (surgical centers) and pharmaceuticals.***
- ☑ ***Our analysis of the $14.5 million in surgical center payments resulted in a range of potential savings with a midpoint of approximately $8.4 million, or 58 percent.***
- ☑ ***Under the new reforms, State Fund would have saved $18 million (24 percent) on its 2002 payments for pharmaceuticals that we were able to analyze. However, if litigation related to the pricing of Medi-Cal pharmaceuticals is successful, the savings would be $14.6 million (19 percent).***

continued on next page

RESULTS IN BRIEF

Effective January 1, 2004, Chapter 639, Statutes of 2003, brought major changes to the workers' compensation medical payment system. The new law requires that payments for services performed in an outpatient surgical facility outside of a hospital setting (surgical center) or an outpatient surgical facility in a hospital not exceed 120 percent of the fee for the same procedure under Medicare's ambulatory payment classification (APC) facility fee schedule. The new law also requires that for pharmacy services and drugs that Medicare's APC fee schedule does not otherwise cover, payments be limited to 100 percent of the relevant Medi-Cal fee schedule. To determine the extent to which these reforms would produce savings in medical costs, we reviewed medical payments that the State Compensation Insurance Fund (State Fund) made in 2002. Although data limitations constrained our analysis, the data we were able to analyze showed that the recent reforms would produce savings in the form of lower payments for fees for the use of facilities (facility fees)[1] at outpatient surgical facilities and pharmaceuticals.

As the Joint Legislative Audit Committee (audit committee) requested, in August 2003 the Bureau of State Audits released a report of the workers' compensation medical payment system, titled *California's Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care*. That report describes how rising medical costs are contributing to the increasing costs of the workers' compensation medical payment system—costs that California's employers are required to pay. Along with other findings, the report states that fee schedules intended to control the amounts paid for medical services are outdated or nonexistent.

To address the audit committee's request that we focus on payments for workers' compensation medical services that hospitals and surgical centers provided and insurance companies

[1] According to the new reforms, payments for outpatient surgeries that take place in a hospital or surgical center are based on a payment system used by Medicare. Under Medicare rules, the payment made for outpatient surgeries compensate providers for the use of the facilities and any supplemental supplies and other services directly related to the medical procedures performed, and are known as facility fees.

- ☑ *Our analysis was limited because the data entered into State Fund's medical bill review file were often incomplete, individual items were summarized without retaining their unique identifiers, and the database design prevented certain detailed analysis.*
- ☑ *The savings we identified depend on the careful implementation of the newly legislated reforms. However, according to the Division of Workers' Compensation's (division) administrative director, his efforts to implement reforms have been hampered by hiring freezes and budget shortfalls.*
- ☑ *The division continues to lack a comprehensive database to monitor workers' compensation medical payments.*

(insurers) paid for, we relied on medical payment data from State Fund, which paid more than a quarter of the medical costs related to California's insured employers in 2002. Although State Fund provided the information we needed to determine that increases in workers' compensation medical costs were being driven more by an increase in the number of services that medical service providers (providers) were performing than by an increase in the average cost of services, State Fund was not able to provide us with other information we sought in order to analyze facility fees paid to surgical centers and pharmaceutical payments for our August 2003 report. As a result, we are presenting our analysis of payment data in this follow-up report.

For this second report, we obtained medical claims payment data from State Fund to determine the extent to which the new legislative reforms would have produced savings in workers' compensation medical costs had they been in effect during 2002. We limited our analysis to data in the medical bill review files that State Fund provided us, and we did not attempt to trace the recorded payments to supporting documents. However, because of limitations in State Fund's data, we were able to analyze only $14.5 million of the $43 million in identifiable facility fee payments to surgical centers that State Fund processed through its medical bill review database during 2002. State Fund's management contends that its databases were designed not for research purposes but rather to provide accurate reimbursement payments that comply with state law. Because these limitations precluded a comprehensive analysis of the data, we used for our analysis Medicare's ambulatory surgical center (ASC) fee schedule, which has only nine groups of procedure classifications, rather than Medicare's APC fee schedule, which has 569 procedure groups. Because the APC fee schedule is more generous overall than the ASC fee schedule, the potential savings would have been less if we had used the APC fee schedule.

Our analysis of the $14.5 million in surgical center payments resulted in a range of potential savings with a midpoint of approximately $8.4 million, or 58 percent. The payments State Fund made to surgical centers was to compensate providers for the use of the facilities and to pay for the supplemental supplies and other services related to medical procedures performed. The physicians who perform the medical procedures are compensated according to a separate fee schedule. Because of the limitations in State Fund's medical bill review database, we had no basis for calculating whether this level of savings would

have been possible in the remaining $28.5 million in payments State Fund made to surgical centers or in the unknown amount of settlements it paid to surgical centers as a result of litigated payments. Therefore, we cannot reliably conclude that the payments we analyzed are representative of State Fund's total payments to surgical centers or that the savings we found are representative of the savings possible in all of State Fund's payments to surgical centers. However, we were able to analyze approximately $76 million, which represents 83 percent of the total $91.7 million paid for prescription drug purchases in 2002 for which State Fund recorded sufficient information and estimated that it would have saved $18 million, or 24 percent, had the new reforms been in place during that year.[2]

Our analysis was limited for three reasons: (1) the data State Fund entered into its medical bill review database were often incomplete, (2) individual items were summarized into general categories and entered into the system without retaining their unique identifiers, and (3) the database design is such that certain detailed analysis is impossible. We could not make a comprehensive estimate of the potential savings associated with the change in the maximum facility fee payments to surgical centers that the new law called for because of the manner in which State Fund collects and classifies facility fee payments it makes to surgical centers for supplemental items such as drugs and supplies in addition to the fee it pays for using the facility. Also, although State Fund often pays surgical centers less than the amounts billed when it considers the amounts excessive, it neither tracks the additional litigated settlement payments it makes—payments that arise from its capping these charges—nor links such payments to the original payment amounts in the medical bill review database to reflect the total amount State Fund pays the surgical centers. We also encountered limitations in the data related to payments for pharmacy services and drugs. Lacking such data, we could not compute all of the potential savings that would have resulted had the new law already been in effect during 2002.

Although the condition of the data in State Fund's medical bill review file limited our analysis of individual payments to surgical centers, and to a lesser degree payments for pharmaceuticals, State Fund contends that its data meets its

[2] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments effective January 1, 2004, that a preliminary injunction partially blocked. Without the 5 percent reduction, savings are estimated at $14.6 million, or 19 percent, for 2002.

business purposes and the needs of other research entities. According to State Fund's management, "The State Fund's databases were designed to allow the State Fund to carry out our mission to provide workers' compensation coverage to California employers and to provide those benefits due to their injured employees under California's workers compensation law. Our databases were not designed for public policy research purposes. As we recognize the importance of accurate information to further research and study the workers compensation system we provide data as well as financial and manpower support to the California Workers Compensation Institute, the Workers Compensation Insurance Rating Bureau and the Workers Compensation Research Institute. Our data has been consistently and successfully used by each organization in their studies and reports. State Fund databases are fully sufficient to the task of making and recording accurate compensation and medical benefit payments. Difficulties encountered in completing public policy research must be differentiated from the process of making accurate benefit payments. We are currently implementing two major claims systems development initiatives. Upon completion of these initiatives we will realize a number of business efficiencies. These improvements will include improved data capture at the detail level that, while not altering reimbursement amounts, will further increase the value of the data for research analysis purposes."

Under the new legislation, the California's workers' compensation system may realize additional savings in the form of reduced litigation and reduced amounts in individual insurer's spending to contain spiraling medical costs. For example, during 2002 State Fund paid a preferred provider organization almost $27 million in cost containment fees to gain access to a network of medical providers who were under contract to provide services at negotiated rates. Because provisions in the new law provide similar cost containment, State Fund could largely avoid such fees in the future.

In our analysis of State Fund's payments to surgical centers during 2002, we found a number of instances in which a fee schedule would have standardized payments and resulted in savings. For example, the average amount State Fund paid to individual surgical centers for the use of their facilities sometimes exceeded 300 percent of the Medicare ASC rate, adjusted to reflect the highest California wage index. In addition, the State's official medical fee schedule in place during 2002 required that State Fund pay a reasonable fee for

a broad range of items, such as drugs and supplies, associated with outpatient surgical procedures. In some instances, these supplemental payments far exceeded the facility fees involved. Medicare's APC and ASC fee schedules include such items in the facility fee and do not require separate payment.

However, unless the administrative director of the Division of Workers' Compensation (division) ensures that the new reforms are promptly and effectively implemented, the savings may not be fully realized. On December 30, 2003, the division's administrative director posted on the division's Web site proposed emergency regulations to implement the medical fee schedules that the law required. On the same day, the administrative director submitted the proposed emergency regulations to the Office of Administrative Law for review and approval. These proposed regulations attempt to address the issues we identify in this report relating to implementing the newly mandated payment system for services that surgical centers performed, including capping payments at fee schedule amounts and bundling the amounts that insurers pay for drugs and supplies into the facility fee.

Nonetheless, the emergency regulations that the administrative director proposed do not assure the permanent successful implementation of the workers' compensation payment system that the new law mandated. Assuming that the Office of Administrative Law accepts the regulations as written, the emergency regulations will remain in effect for only 120 days. Prior to their expiration, the administrative director must either provide permanent regulations, along with a statement that the regulations comply with all regular rule-making procedures, to the Office of Administrative Law or request that it approve the readoption of the emergency regulations. Therefore, the savings that will result from the payment system that the new law requires will remain unknown until the Office of Administrative Law finalizes and approves the emergency regulations and providers, insurers, and claims administrators who participate in the workers' compensation program interpret and implement them.

Having adequate and reliable medical payment data is critical to any attempt to analyze and monitor how well the workers' compensation system delivers quality care to injured workers at costs that the law allows, as well as to efforts to track the effect of policy changes on the system's performance and costs. However, based on the findings in our first report on California's workers' compensation medical payment system and the knowledge we gained regarding State Fund's medical bill review

database during this review, we found that California does not have a database of workers' compensation medical payments that can provide detailed and reliable data for such analysis and monitoring. The division's administrative director told us that the State's hiring freeze and budget shortfalls have hampered his efforts to implement workers' compensation reform.

The division is currently developing a workers' compensation database, the Workers' Compensation Information System, intended to provide the type of information the division needs to analyze and monitor system performance. However, both the division's survey of insurers and our own analysis of the medical payment data that State Fund provided revealed that both State Fund's and the other insurers' data files appear to be incomplete or the data in the files are inaccurately and inconsistently classified. Therefore, neither the insurers nor the division—once these data are reported—will be able to use the data to make informed decisions.

RECOMMENDATIONS

To fully realize the savings from the new reforms to the workers' compensation medical payment system, the division's administrative director must continue to provide the workers' compensation community with the ongoing education and guidance that will ensure that the reforms are promptly and effectively implemented.

The division should ensure that the medical payment data it collects in the Workers' Compensation Information System provides the specific information the division needs to adequately monitor medical payments for compliance with the payment system and for the effectiveness of policy decisions. Specifically, the division should first clearly define the data elements it requires from insurers and claims administrators; second, it should obtain the medical payment data using a standardized reporting instrument, which will ensure that insurers and claims administrators consistently and completely report the data in such a way that it will be useful for the division's analysis and monitoring.

AGENCY COMMENTS

The Labor and Workforce Development Agency (agency) cited the administration's overall goal of reducing costs. Keeping that in mind, the agency stated that the Department of Industrial Relations' Division of Workers' Compensation (division) is working with insurers and claims adjusters to develop a cost-neutral method to transmit electronic medical payment information to the division's Workers' Compensation Information System. The agency also stated that the audit confirms that the 2003 workers' compensation reform package will provide some cost relief to California's employers while citing the administration's belief that more reform is needed.

The State Compensation Insurance Fund (State Fund) stated that its databases are constructed in a manner that is consistent with the current state of the art within the workers' compensation industry. State Fund also acknowledged that using a workers' compensation carrier's large medical and compensation databases for public policy research is very labor intensive and demanding. State Fund believes its databases are fully sufficient to make and record accurate compensation and medical benefit payments, and that difficulties encountered in conducting public policy research must be differentiated from the process of making accurate benefit payments. State Fund is currently implementing two major claims systems development initiatives that it stated will improve data capture at the detail level and increase the value of the research analysis while not altering reimbursement payments. State Fund looks forward to the opportunity of working with the administration and the Legislature to make the improvements still required in the workers' compensation system. ■

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INTRODUCTION

BACKGROUND

California's workers' compensation program requires employers to compensate workers for work-related injuries and illnesses. Injured workers are entitled to receive all medical care that is reasonably required to cure or relieve the effects of the disability. Additionally, workers who are temporarily or permanently unable to return to work are entitled to receive disability benefits to partially replace lost wages; they may also be entitled to grants to pay for vocational rehabilitation if they are unable to return to the same line of work.

No single government or private entity administers the workers' compensation program. Rather, employers, insurance companies (insurers), claims administrators, medical service providers (providers), and others all have roles in processing workers' claims for benefits. When providers disagree with payers (that is, insurers or claims administrators) on benefits, payments, or necessary medical services for injured workers, the parties settle their disputes through proceedings before workers' compensation administrative law judges or the Workers' Compensation Appeals Board.

The workers' compensation system requires employers to pay the costs of workers' compensation benefits through a financing system that includes three methods: (1) large, stable, or government employers may pay for benefits directly through self-insurance; (2) employers may purchase insurance from any of the insurers that the Department of Insurance has licensed to offer workers' compensation insurance in California; or (3) employers may purchase workers' compensation insurance through the State Compensation Insurance Fund (State Fund). State Fund is a state-operated entity that exists solely to provide workers' compensation insurance on a nonprofit basis. It actively competes with private insurers for business, and it also provides workers' compensation insurance to employers that cannot secure the coverage from other insurers.

Until recently, California's workers' compensation medical payment system consisted of a combination of fee schedules, payment formulas, and payments to providers based on the providers'

Medical Services for Which No Fee Schedule Limited Charges Prior to January 1, 2004

- Services at outpatient surgical facilities in a hospital.
- Services at outpatient surgical facilities outside of a hospital setting.
- Home health care services.
- Ambulance services.
- Emergency room services.

usual, customary, and reasonable charges for medical services. Prior to the legislative reforms that took effect on January 1, 2004, the workers' compensation medical payment system used the Official Medical Fee Schedule (OMFS) in part, to determine reimbursement rates for some medical services provided under the workers' compensation program. Although the OMFS provided control over the costs of some medical services, such as physician fees and hospital inpatient services, it had no control over the costs of the services shown in the text box or over services covered under other payment systems, such as Medicare.

FINDINGS FROM OUR AUGUST 2003 AUDIT

This is the second Bureau of State Audits' report related to an audit that the Joint Legislative Audit Committee (audit committee) originally requested. The first report, titled *California's Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care* (Report 2003-108.1) and released in August 2003, was an audit of the workers' compensation medical payment system. That report describes how rising medical costs are contributing to the increasing costs of the workers' compensation system—costs that California's employers are required to pay. Along with other findings, we concluded that fee schedules intended to control the amounts paid for medical services and products are outdated or nonexistent. In addition, we reported that the state entity responsible for administering and monitoring the workers' compensation program, the Department of Industrial Relations' Division of Workers' Compensation (division), lacks a data collection system that allows it to monitor medical costs and measure the effectiveness of reforms made to the system.

We recommended that the division, when determining the future structure of the medical payment system, consider the costs and practicalities of maintaining such a complex system and consider adopting a payment system that is based on models already in use, such as a variation of Medicare's resource-based payment system, which the federal Centers for Medicare and Medicaid Services maintains. We also recommended that the division develop a time line for completing its new data

collection system, the Workers' Compensation Information System, and ensure that the data it collected would provide the information necessary to adequately monitor medical costs and services.

In addition to a general review of medical costs and the payment structure of the workers' compensation insurance system, the audit committee requested that we focus on payments that workers' compensation insurers made to outpatient surgical facilities. Insurers pay outpatient surgical facilities outside of a hospital setting (surgical centers) for the use of the facilities and supplemental supplies and other services related to the medical procedures performed. (The physicians who perform the medical services are compensated in accord with a separate fee schedule.) To address this request, we obtained medical payment data from State Fund, the workers' compensation insurer with the largest market share in the State. We were able to analyze the data to determine that increases in State Fund's workers' compensation medical costs were being driven more by an increase in the number of services performed than by an increase in the average price per service. However, State Fund was not able to provide us all the information we needed in order to analyze payments to outpatient surgical facilities and for pharmaceuticals in time to present the results in our August 2003 report.

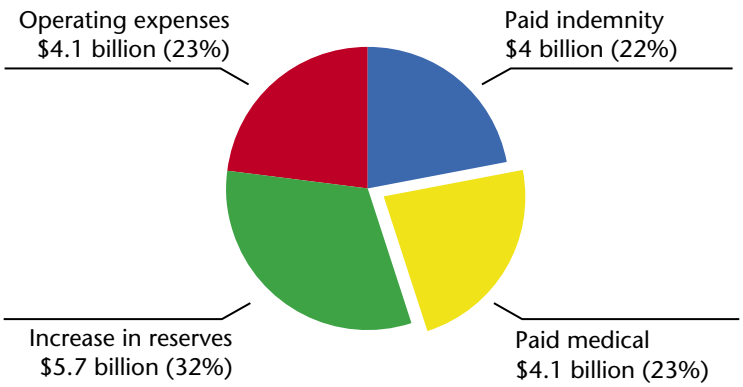
STATE FUND'S ROLE IN WORKERS' COMPENSATION

According to the data State Fund reported to the Workers' Compensation Insurance Rating Bureau (rating bureau), a nonprofit association of insurers that serves as the statistical agent for the State's insurance commissioner, State Fund's operations represented approximately 37 percent of California's workers' compensation insurance premiums earned during 2002 (55 percent when insurers' earned premiums are shown net of deductible credits), and State Fund paid 27 percent of the medical costs related to insured employers during that year.

The rating bureau reported that insurers paid workers' compensation costs for injured employees of more than $17.9 billion in 2002, with medical costs, including pharmaceuticals, representing approximately $4.1 billion, or 23 percent of the total. Figure 1 on the following page shows the proportionate costs of the workers' compensation program that insurers, including State Fund, paid. Figure 2 on page 13 shows the paid medical costs State Fund reported to the rating bureau compared to the medical payments that other insurers reported.

FIGURE 1

Insurers' California Workers' Compensation Costs for 2002*



Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

* Total costs for insurers were over $17.9 billion. Some large, stable, or government employers may pay for employees' benefits directly through self-insurance.

Included in its reports to the rating bureau is an amount of $144.7 million that State Fund paid for the following three reasons: (1) to settle disputed medical bills, (2) to pay injured workers directly, and (3) to pay cost containment expenses such as access fees to a preferred provider organization to gain access to a network of providers who perform medical services at negotiated rates. The remaining amounts shown in Figure 2 consists of about $880 million for medical costs and $91.7 million for prescription drugs that State Fund processed and paid through its automated medical bill review system during 2002.

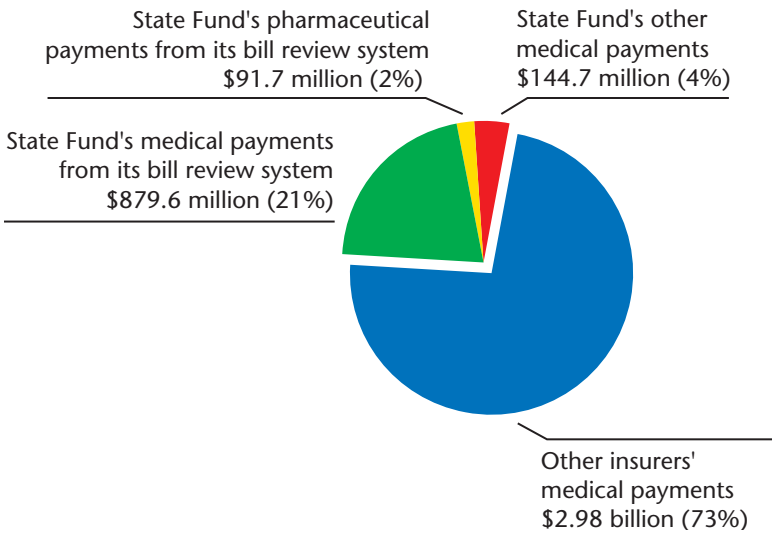
Included in the $880 million State Fund made in medical payments is about $203 million it paid to health care facilities in 2002. Payments to these facilities are broken out as follows:

- $56 million to physical rehabilitation facilities, such as long-term care facilities and home health care.

- $34 million to inpatient hospital facilities when the medical procedure performed required an overnight hospital stay.

FIGURE 2

Comparison of Medical Payments Reported by State Fund and Other California Workers' Compensation Insurers in 2002*


State Fund's pharmaceutical payments from its bill review system $91.7 million (2%)
State Fund's other medical payments $144.7 million (4%)
State Fund's medical payments from its bill review system $879.6 million (21%)
Other insurers' medical payments $2.98 billion (73%)

Source: The Workers' Compensation Insurance Rating Bureau and the State Compensation Insurance Fund.

* Medical payments by all insurers totaled $4.1 billion.

- $70 million to outpatient surgical facilities in hospitals when they perform surgical procedures that do not require an overnight stay (outpatient surgeries).

- $43 million to surgical centers when they perform outpatient surgeries.

This audit focuses on the $43 million State Fund paid to surgical centers and the $91.7 million it paid for drugs in 2002. These amounts make up 12 percent of State Fund's total medical costs for that year.

RECENT LEGISLATION CHANGES THE WORKERS' COMPENSATION MEDICAL PAYMENT SYSTEM

Effective January 1, 2004, Chapter 639, Statutes of 2003, addresses many of the findings in our August 2003 audit report and brings major changes to the workers' compensation medical payment system. Regarding workers' compensation medical costs, the new law generally sets requirements for medical fee schedules and establishes more control over the use of medical

and professional procedures in treating injured workers. Specific to this audit, the new law requires that payments of fees for the use of facilities for services performed in an outpatient surgical facility, whether in a hospital or nonhospital setting, not exceed 120 percent of Medicare's ambulatory payment classification (APC) facility fee schedule. Payments to surgical centers and hospital outpatient surgery departments under Medicare are intended to compensate the provider for the use of the facility and any supplemental supplies and other services directly related to the outpatient surgical procedures performed (facility fee). (The physicians who conduct the outpatient surgical procedures are compensated separately in accord with another fee schedule.) The new law also requires that payments for pharmacy services and drugs that are not otherwise covered under Medicare's APC fee schedule be limited to 100 percent of the relevant Medi-Cal fee schedule.

The federal Medicare program uses payment systems that base their fee schedules on the resources determined necessary to provide medical services. In simplified terms, under these systems, Medicare determines payments to outpatient surgical facilities using a schedule that indexes each medical service or service group as a value in relation to the value of a common service or service group that the federal program uses as a baseline. These values are determined based on the resources considered necessary to provide the medical services. Because these payments are derived from the estimated resources required to provide the services, they are tied more to the cost to provide the services than to the amounts that providers customarily charge for them, and they are intended to control payment inflation.

Medicare pays facility fees for outpatient surgeries under two systems: the Hospital Outpatient Prospective Payment System and the ambulatory surgical center (ASC) fee schedule. The schedule Medicare uses depends on whether the provider performs an outpatient surgical procedure in a hospital setting or in a surgical center. For the former, Medicare uses the Hospital Outpatient Prospective Payment System, which categorizes services into 569 procedure groups, called APCs. Services that are grouped within the same APC are similar and require a similar level of resources. For outpatient surgical procedures performed at a surgical center, Medicare uses the ASC fee schedule, which consists of nine groups of similar procedures that require similar resources, each with its own payment rate. For both the APC and ASC payment systems, Medicare calculates the

payment for a specific service group by adjusting the rate using a geographic adjustment factor to compensate for the varying costs of providing medical services in different geographic zones. Medicare identifies 25 different geographic zones in California.

The Department of Health Services (Health Services) is responsible for administering the Medi-Cal program, which contains a prescription drug benefit. Health Services controls the cost of pharmaceuticals under Medi-Cal in part by using a drug formulary—a list of drugs, known as the contract drug list, that a physician can prescribe and for which a pharmacy can seek reimbursement without first obtaining approval from Health Services. Medi-Cal pays for drugs using the lowest of three predetermined reimbursement rates or the actual charge. According to Health Services, Medi-Cal pays for most of the drugs at the average wholesale price less 10 percent, plus a dispensing fee and less any rebates from the drug's manufacturer. The average wholesale price is the price that its manufacturers assign to the drug and that commercial organizations such as First DataBank compile. Because of the State's budget deficit, beginning January 1, 2004, Medi-Cal reduced most of its payments for services by 5 percent, including payments for prescription drugs.[3] The reduction will remain in effect until January 1, 2007.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that we review the medical costs related to the workers' compensation insurance system and the extent to which the billing structure has resulted in unacceptably high reimbursement rates. The audit committee specifically requested that we focus on medical services provided by hospitals and outpatient surgical facilities and paid for by workers' compensation insurers.

In August 2003 we issued our first report, titled *California's Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care* (Report 2003-108.1).

[3] A preliminary injunction partially blocked the 5 percent reduction.

To arrive at that report's findings, we performed extensive procedures to understand the governance structure and the issues surrounding the medical payments made in the workers' compensation system, as well as to identify sources of available billing and payment data. In addition, we reviewed numerous research reports on workers' compensation in California and other states and conducted a survey of 10 other states that had implemented workers' compensation payment systems patterned on Medicare's resource-based payment system. Finally, we obtained medical claims data from State Fund and determined, for all the employees it covers, the extent to which increases in workers' compensation medical costs were being driven by increases in the average price per service or by an increase in the number of services performed. We requested data from State Fund because it paid more than 25 percent of all California's workers' compensation medical costs related to insured employers in 2002. However, State Fund was not able to provide us with other information we sought at that time. Therefore, we were unable to analyze State Fund's payment data on payments to outpatient surgical facilities and payments for pharmaceuticals in time to present the results in our August 2003 report. As a result, we are presenting our analysis of payment data in this follow-up report.

For this report, we analyzed payments State Fund made to surgical centers and for pharmaceuticals that were included in its medical bill review system for 2002; we sought to determine the extent to which employers and insurers could achieve savings in workers' compensation medical costs by adopting a fee schedule based on the Medicare ASC fee schedule and a pharmaceutical fee schedule similar to Medi-Cal's. Although new legislation requires the Department of Industrial Relations' Division of Workers' Compensation (division) to adopt a fee schedule for outpatient surgical facilities' facility fees that equals 120 percent of Medicare's APC fee schedule, for reasons we will explain more fully below, we calculated the potential savings by using 120 percent of Medicare's ASC fee schedule. Because limitations in State Fund's data precluded a comprehensive analysis, we used Medicare's ASC fee schedule, with its nine groups of procedure classifications, for our analysis, rather than Medicare's APC fee schedule, with its 569 groups. Medicare makes a single payment to surgical centers to compensate for the use of the physical space as well as for any supplies or services that directly relate to the surgical procedure performed.

Because of the limitations in State Fund's data, we were unable to analyze 66 percent of the $43 million in payments to surgical centers made in 2002. The transactions we were unable to analyze lacked specific information. For example, because State Fund's bill review system cannot calculate payments for transactions that are not covered by a fee schedule, such as facility fees paid to surgical centers, its bill reviewers calculate those payments outside the system and manually enter them into the medical bill review system. In some instances, the reviewers entered only summary information that precludes detailed analysis; and in others, State Fund's data did not directly link individual payments to individual procedures. In addition, the individual payment records from State Fund's data did not contain codes identifying the specific procedures it paid for. We partially overcame this obstacle by linking the payments State Fund made to the surgical centers to the payments it made to physicians for the same procedure and using the physician procedure code to identify the facility procedure code. Nonetheless, we were able to analyze only 34 percent of State Fund's 2002 payments to surgical centers. We limited our analysis to the data contained in the medical bill review files State Fund provided us and did not attempt to trace the recorded payments to supporting documentation.

We identified significant savings associated with the payments for which State Fund's medical bill review system contained sufficient detail for analysis. We also identified those surgical center providers who rendered services at prices not controlled by contract and who received the highest average payments for facility fees and services during 2002. However, because we could not determine the nature of the payments for which State Fund maintained insufficient data, we cannot know whether the payments we did analyze are representative of all the medical payments State Fund provided. As a result, we cannot reliably project the size of possible savings for all of State Fund's payments to surgical centers. We planned on presenting information regarding medical providers that received payments in 2002 that significantly exceeded Medicare's rates for similar services; however, State Fund asserted that such information was confidential.

To calculate the potential savings from adopting a fee schedule for prescription drugs, we compared State Fund's average payments for prescription drugs in 2002 to the amount California's Medi-Cal program would have paid for the same drugs. Medi-Cal pays for prescription drugs using the lowest

among the actual charge or one of three predetermined payment methods. We used the payment method that Health Services, which administers Medi-Cal, told us the program uses most commonly. After January 1, 2004, this method is 95 percent of the sum of a drug's average wholesale price minus 10 percent, plus a $3.55 dispensing fee.[4] Of the $91.7 million State Fund paid for pharmaceutical purchases, we were able to analyze approximately $76 million for potential savings. Of the remainder, records of $2.8 million in payments for pharmaceuticals lacked sufficient detail for further analysis, and $2.9 million in payments were for drugs we were unable to match with a list of drug wholesale prices that Health Services provided us. State Fund also paid $10.1 million for supplies and injections for which the data did not allow us to identify the location where they were administered so as to identify whether the new reforms would have applied to these items. As a result, we did not include these payments in our price comparison analysis.

Finally, we asked the division about its plans for implementing the new legislation's fee schedule requirements and completing the implementation of the new data collection system, the Workers' Compensation Information System. ■

[4] A preliminary injunction partially blocked the 5 percent reduction, which was to become effective on January 1, 2004.

CHAPTER 1

Changes to the State's Workers' Compensation Medical Payment System Will Cause Payments for Outpatient Surgical Facility Services and Prescription Drugs to Drop Sharply

CHAPTER SUMMARY

California's workers' compensation system will benefit from recent legislation that requires the adoption of fees based on Medicare and Medi-Cal fee schedules. Legislation that became effective on January 1, 2004, limits payments of fees for the use of outpatient surgical facilities (facility fees), whether medical services were rendered in a hospital outpatient surgery department or an outpatient surgical facility outside of a hospital setting (surgical center), to 120 percent of Medicare's ambulatory payment classification (APC) fee schedule.[5] It also limits payments for pharmaceuticals to 100 percent of the Medi-Cal fee schedule.

Our analysis indicates that had similar reforms been in place during 2002, the State Compensation Insurance Fund (State Fund) could have saved anywhere from $7.8 million to $8.9 million (with a midpoint of $8.4 million) of the amount it paid to surgical centers for facility fees. These savings represent about 54 percent to 61 percent, respectively (with a midpoint of 58 percent), of the payments in State Fund's medical bill review database that contained sufficient detail for analysis. In some cases, the average amount State Fund paid a surgical center for the facility fee exceeded 300 percent of the rates in the Medicare ambulatory surgical center (ASC) fee schedule. We also calculated that State Fund could have saved another $18 million (or about 24 percent) on the amount it spent on prescription drugs.[6]

[5] In the emergency regulations proposed on December 30, 2003, by the administrative director of the workers' compensation program, the facility fees for outpatient surgical facilities are calculated at 122 percent of the Medicare APC fee schedule. The 2 percent in excess of the 120 percent of Medicare's fees required by new legislation is intended to compensate providers for more costly "outlier cases" in lieu of the Medicare calculation of payments for outlier cases, which requires determining cost-to-charge ratios for outpatient surgical facilities.

[6] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments effective January 1, 2004, which a preliminary injunction partially blocked. Without the 5 percent reduction, we estimate savings at $14.6 million, or 19 percent, for 2002.

Because of the way State Fund collects and classifies medical payment data, we were able to analyze only $14.5 million (or 34 percent) of the $43 million in identifiable payments that State Fund made to surgical centers during 2002. Our analysis was limited for two reasons: (1) the medical payment data were incomplete, inconsistent, or too general; and (2) features of the database design made detailed data analysis impossible. Although we believe that, had we been able to fully analyze the data related to facility fees and drug supplies, we could have identified even more savings, we cannot reliably conclude that the level of savings we found in the payments we reviewed is representative of all State Fund's payments.

According to State Fund's management, its databases were designed to carry out its mission to provide workers' compensation coverage to California employers and to provide the benefits due to their injured workers according to the law; the databases were not designed for public policy research purposes. State Fund's management nonetheless stated that it recognized the importance of accurate information to further research and study the workers' compensation system. Management further stated that, although not affecting the accuracy of its bill reviews or reimbursement payments, the manner in which State Fund currently collects and classifies its data does not always allow for an extensive detailed analysis. Lastly, State Fund's management indicated it was upgrading its medical bill review system and was concurrently involved in a project to allow electronic filing of claims, thus consolidating and automating many of the claims-processing functions, including streamlining the bill review and payment processes and ensuring a more complete, accessible, and accurate database.

Once California implements the reforms to the workers' compensation medical payment system, State Fund may be able to reap additional savings by reducing its cost to litigate medical claims and avoiding what it now spends to contain its spiraling medical costs. In addition, it could save on the cost of supplemental payments for a broad range of items, such as drugs and supplies, associated with outpatient surgical procedures. Neither one of Medicare's facility fee schedules for outpatient surgeries pays these items separately. In some instances, State Fund's supplemental payments far exceeded the facility fees involved. Unless the workers' compensation reforms are carefully implemented by all stakeholders, such supplemental payments could circumvent the controls intended to contain these costs.

OUR REVIEW OF STATE FUND'S PAYMENTS TO SURGICAL CENTERS SHOWS THE POTENTIAL FOR SAVINGS

California's workers' compensation system will benefit from recent legislation that requires the adoption of fees based on Medicare fee schedules for surgical center services. Reviewing the 2002 payments to surgical centers for those outpatient surgical services from State Fund's medical bill review system that contained sufficiently detailed information for our analysis, we calculated the savings that would result from adopting a fee schedule that limits payments to 120 percent of the Medicare ASC fee schedule. For reasons we discuss later in this chapter, we were able to analyze individually only $14.5 million of the $43 million (or 34 percent) that State Fund's medical bill review system recorded as payments to surgical centers for facility use and payments for supplemental services and supplies. Nonetheless, we calculated that State Fund would have saved between $7.8 million and about $8.9 million, using the geographic index for the highest- and lowest-cost areas in California, respectively, and limiting payments to 120 percent of Medicare's ASC fee. These savings represent about 54 percent to 61 percent, respectively, of the payments in State Fund's medical bill review database that we were able to analyze. However, because we do not know the nature of the payments we could not analyze, we cannot know whether the transactions we did analyze are representative of all the medical payments State Fund made. As a result, we cannot reliably conclude that the savings we found reflect the savings possible in all of State Fund's payments.

Of the $14.5 million in payments to surgical centers that we analyzed, State Fund would have saved between $7.8 million and $8.9 million had the recent reforms been in place.

State Fund makes payments to two types of surgical centers: (1) independent surgical centers and (2) surgical centers that contract with a preferred provider organization (PPO) that, in turn, contracts with State Fund to provide services through its network of medical service providers (providers) at negotiated rates. Although State Fund contracts with the PPO with the intent of controlling rising medical costs through negotiated rates, we found that adopting Medicare-based fee schedules would result in lower payments to both the surgical centers under contract with the PPO and the independent surgical centers. We found that for the payments to surgical centers that State Fund made through a PPO during 2002, State Fund would have saved $5.4 million to $6 million (or 58 percent to 65 percent) if it had limited payments to 120 percent

of Medicare's ASC fees for high-cost and low-cost areas, respectively. For independent surgical centers, State Fund would have saved $2.4 million to $2.9 million (or 46 percent to 54 percent).

We found that adopting Medicare-based fee schedules would result in lower payments to both the surgical centers under contract with the preferred provider organization and the independent surgical centers.

Our analysis shows that the savings appear to be greater for the payments to surgical centers associated with the PPO because the nature of these payments is different than that of payments made to independent surgical centers. State Fund's payments to surgical centers through the PPO are at rates that the provider and the PPO negotiated; such payments do not result in disputes between the parties over the appropriate payment for the services rendered. In contrast, in the absence of predetermined fees for outpatient surgical services, State Fund attempts to control costs that independent surgical centers charge by unilaterally imposing limits on the fees it will pay them. According to its management, State Fund caps payments at 200 percent of what Medicare would pay for a similar procedure. This cap may result in a dispute that can lead to additional payments by State Fund. However, when State Fund makes additional payments to surgical centers to settle billing disputes, it does not link those additional payments to the original claims in its medical bill review database. As a result, the payments State Fund ultimately makes to independent surgical centers may be even higher than the payments we analyzed from the medical bill review database because State Fund does not include additional payments already made or to be made to these providers to settle disputes that arise from State Fund's practice of capping these payments.

Our Analysis Reflects Savings Using the Medicare ASC Payment System

For our analysis, we compared the amounts State Fund actually paid surgical centers to the amounts that it would have paid using 120 percent of the Medicare ASC fee schedule, rather than 120 percent of the Medicare APC payment system, which is the maximum payment level in the new reform legislation. Medicare uses the APC payment system to pay for services performed in outpatient surgical facilities in a hospital setting, and it uses the ASC payment system to pay for services performed in surgical centers. Because the APC fee schedule is more generous than the ASC fee schedule, the potential savings would have been less if we had used the APC fee schedule. However, because limitations in State Fund's data precluded a comprehensive

analysis, we used Medicare's ASC fee schedule, which has only nine groups of procedure classifications, rather than Medicare's APC fee schedule, which has 569 procedure groups.

Like Medicare's APC payment system, the ASC payment system uses geographic wage adjustments in calculating payment levels for facility fees. Medicare currently uses 25 different geographic wage indexes to compute surgical center facility fees in California, and thus the amount of a payment for a given service will depend on the facility's location. Rather than applying the appropriate geographic wage index to each payment we analyzed to determine potential savings, we calculated a range of savings using California's lowest and highest wage index. In Appendix A, we present the savings by Medicare ASC procedure group using Medicare's lowest and highest wage index in California.

Under the 2002 rules for California's workers' compensation program, providers received a fee for the use of the surgical center itself; and could charge supplemental fees for services related to the surgery performed, such as providing necessary drugs and supplies.

When we compared State Fund's 2002 payments to surgical centers to 120 percent of Medicare's ASC rate for similar surgical procedures, we included all of the services related to the surgical procedures performed on a particular day. This methodology closely reflects Medicare's payment method, which bundles those services together with the charge for use of the facility under the facility fee. Under the 2002 rules for California's workers' compensation program, providers received a fee for the use of the surgical center itself; and could charge supplemental fees for services related to the surgery performed, such as providing necessary drugs and supplies. Without a fee schedule in place, in certain circumstances State Fund paid for these services and supplies in addition to the amount it paid for the use of the surgical centers' facilities. Medicare rules for both the APC and ASC fee schedules include supplemental supplies and services in a single facility fee and do not pay them separately. Therefore, we calculated our savings using the bundled payment method that Medicare uses. Of the $7.8 million in savings we calculated using the geographic wage index for high-cost areas, we found that State Fund could save $1.1 million (or 14.1 percent) by using Medicare's rules for bundling the charges for facility services and supplemental services and supplies into a single payment.

Savings From the Surgical Center Fee Schedule Required by New Legislation Will Differ From Our Calculations

Although our comparative analysis using 120 percent of Medicare's ASC fee schedule indicated significant savings associated with the surgical center payments we reviewed, the

Similarities and Differences in the Medicare APC/ASC Fee Schedules

- Medicare uses the APC fee schedule, which has 569 procedure groups, to determine payments to hospitals for outpatient surgical procedures.
- Medicare uses the ASC fee schedule, which has nine procedure groups, to determine payments to surgical centers for outpatient surgical procedures.
- Both the APC and ASC fee schedules use a payment-bundling approach and geographic wage index to calculate facility fee payments.
- Both the APC and ASC fee schedules have rules for bundling services and supplies.

savings that State Fund ultimately realizes will probably not be as great under the new legislation that became effective on January 1, 2004. That is because the new legislation calls for a payment rate not to exceed 120 percent of the Medicare APC payment system. Although the Medicare APC and ASC rates have similarities, the ASC payment system is much less complex for the calculations we performed for this report because it contains far fewer medical procedure groups used to identify specific fees than does the APC payment system. Because Medicare recognizes that hospitals generally have higher operating costs than do surgical centers, the APC payment system contains higher fees for similar outpatient surgical procedures in the ASC payment system. As a result, our analysis using the ASC payment system showed a greater savings on each payment we analyzed than State Fund could realize under the APC payment system.

The percentage of savings we calculated by using the Medicare ASC payment system is similar to the percentage that researchers for the Commission on Health and Safety and Workers' Compensation (commission) calculated. In its April 2003 report (updated in July 2003), the commission projected that the workers' compensation system would save 66 percent on payments for outpatient surgical facility costs in 2004 by adopting a fee schedule equal to 120 percent of the Medicare ASC payment system. This is similar to the 54 percent to 61 percent range we found that State Fund could have saved in 2002 by using Medicare's ASC payment system to pay for surgical center facility services. In the same report, the commission projected that the workers' compensation system would save 41 percent on payments for outpatient facility costs in 2004 by adopting a fee schedule equal to 120 percent of the Medicare APC payment system. However, as we discussed in our August 2003 report, the commission based its estimates of savings on broad assumptions and projections using findings from other research studies that we could not independently verify because the commission's researcher did not maintain the source data used to calculate the savings. In addition, just as we could not with certainty identify the universe of all State Fund payments to outpatient surgical centers, neither could the commission with certainty identify the universe of all payments made to outpatient surgical centers on a system-wide

Similar to the Commission on Health and Safety and Workers' Compensation's projection that the system would save 66 percent on payments for outpatient surgical centers, we found that savings would range from 54 percent to 61 percent for surgical center facility services.

basis. Therefore, we offer no opinion as to the validity of the commission's estimated savings from implementing the changes the new legislation requires in the medical payment system.

POTENTIAL SAVINGS ALSO EXIST IN PHARMACEUTICALS

Under the new reforms, State Fund could have saved $6.2 million, or 15 percent, on name brand prescriptions and $11.8 million, or 33 percent, on generic prescriptions in 2002, for a total savings of $18 million, or 24 percent.

Working with a much larger segment of payments than we were able to use for our comparison for surgical center payments, we determined that State Fund could have saved $6.2 million (or 15 percent) on name-brand prescription drugs and $11.8 million (or 33 percent) on generic prescription drugs in 2002, for a total savings of $18 million (or 24 percent).[7] We calculated these savings by comparing State Fund's payments for prescription drugs during 2002 to the payments it would have made for the same prescription drugs using a maximum payment rate equal to 100 percent of the amount resulting from the payment method Medi-Cal uses most frequently.

State Fund paid $91.7 million for pharmaceutical purchases during 2002. Of this amount, $75.9 million was for prescription drugs we found on a list of drug wholesale prices that the Department of Health Services (Health Services) uses in its Medi-Cal program; $10.1 million was for supplies and injections we could not verify would be affected by the new reforms; $2.8 million was for items for which the data did not allow for further analysis; and $2.9 million was for drugs whose names did not appear on Health Services' list of drug wholesale prices. Of the approximately $76 million State Fund paid for listed prescription drugs, $41 million was for name-brand drugs and $35 million was for generic drugs.

Under California's Official Medical Fee Schedule (OMFS) in effect during 2002, payers compensate for drugs that a physician prescribes at the lower of two rates: the amount the provider charges or a predetermined rate for name-brand and generic drugs. For name-brand drugs, the payment is at a maximum rate of 110 percent of the average wholesale price plus a $4 dispensing fee; for generic drugs, the reimbursement is at a maximum rate of 140 percent of the average wholesale price plus a $7.50 dispensing fee. The new legislation calls for paying for drugs at a maximum rate similar to one that the Medi-Cal program

[7] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments effective January 1, 2004, which a preliminary injunction partially blocked. Without the 5 percent reduction, we estimate savings at $14.6 million, or 19 percent, for 2002.

uses. The Medi-Cal program pays the least among the drug's actual cost or three predetermined methods, most commonly the average wholesale price less 10 percent plus a dispensing fee. Beginning January 1, 2004, Medi-Cal reduced most payments by an additional 5 percent, including payments for prescription drugs.[8] The reduction is effective until January 1, 2007. As a result, we based our comparison on the most commonly used payment method, adjusted for the January 1, 2004, reduction—the average wholesale price less 10 percent plus a $3.55 dispensing fee, less an additional 5 percent.

THE CONDITION OF THE MEDICAL PAYMENT DATA LIMITED OUR ANALYSIS

For payments for medical services not covered by fees established under California's OMFS, such as facility services at outpatient surgical facilities, State Fund's data posed problems that limited our analysis. Using the medical payment data included in the bill review system that State Fund provided for 2002, we attempted to analyze the approximately $43 million we were able to identify as payments it made to surgical centers. However, due to various problems we encountered with these data, we were able to analyze just over $14.5 million of the $43 million (or 34 percent) State Fund paid to surgical centers. According to State Fund's management, its databases were designed to carry out its mission to provide workers' compensation coverage to California employers and to provide the benefits due to their injured workers according to the law; they were not designed for public policy research purposes.

According to State Fund's management, its databases were designed to carry out its mission to provide workers' compensation coverage to California employers and to provide the benefits due to their injured workers according to the law and were not designed for public policy research purposes.

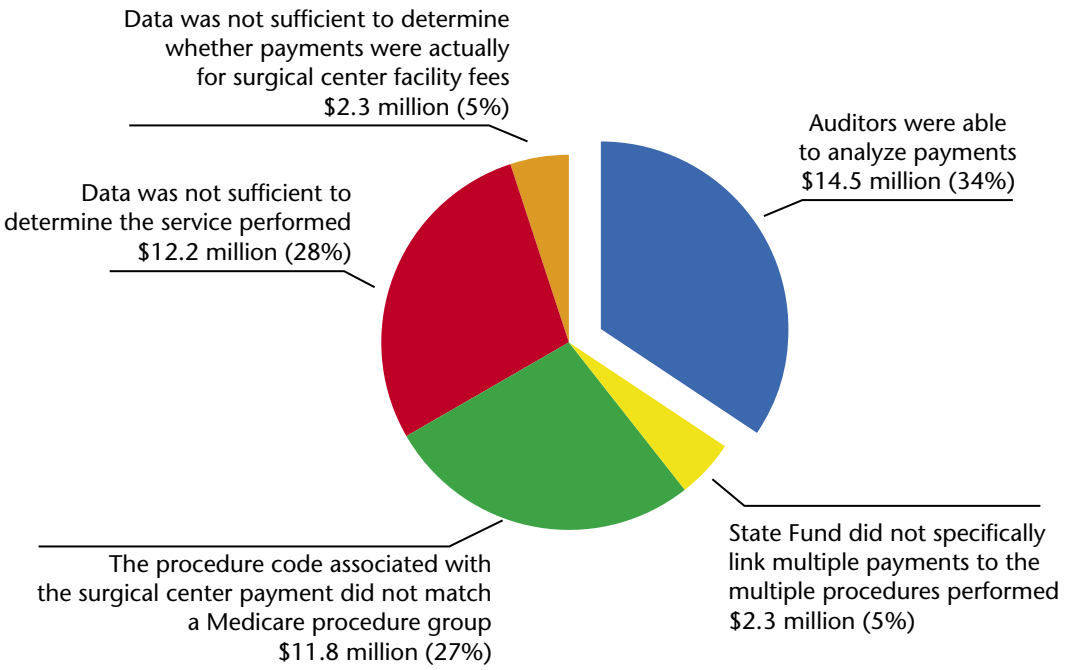
Figure 3 shows the portions of those payments that we could not analyze individually because of problems with State Fund's data, as well as the portion of the data on which we were able to perform a detailed analysis of individual payments.

State Fund's medical bill review database lacks several features in its design that made our detailed data analysis difficult and labor-intensive. One of the difficulties we encountered was that the data State Fund provided did not consistently identify the type of facility in which a procedure was performed. For example, its payment data does not distinguish between

[8] A preliminary injunction partially blocked the 5 percent reduction, which was to become effective on January 1, 2004.

FIGURE 3

Only a Portion of State Fund's Payment Data for Surgical Centers During 2002 Could Be Analyzed*


Data was not sufficient to determine whether payments were actually for surgical center facility fees $2.3 million (5%)
Auditors were able to analyze payments $14.5 million (34%)
Data was not sufficient to determine the service performed $12.2 million (28%)
State Fund did not specifically link multiple payments to the multiple procedures performed $2.3 million (5%)
The procedure code associated with the surgical center payment did not match a Medicare procedure group $11.8 million (27%)

Source: The State Compensation Insurance Fund's medical bill review file.

* Segments total $43.1 million. We rounded this amount to $43 million when discussing it throughout the report.

inpatient and outpatient surgical facilities.[9] To identify and remove inpatient hospital services from the medical payment data, we used the OMFS evaluation and management codes for physician inpatient services and the dates of service; this left only the outpatient services. To isolate payments State Fund made to surgical centers from payments it made to all other types of facilities, we relied on lists of provider identification numbers that State Fund provided, lists that it created outside the medical bill review database.

Another difficulty with State Fund's payment data is that records of payments to surgical centers do not contain information about the type of surgical procedure performed. Without specific information on the types of surgical procedures performed in the surgical centers, we could not complete our price comparison. To overcome this deficiency in the data and

[9] An inpatient is a hospital patient who receives lodging and food as well as treatment; an outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or similar facility such as a surgical center, for diagnosis or treatment.

identify the surgical center services that State Fund paid for, we used physician payment data to link physicians' surgical services to surgical center services. Then, using the specific surgical procedures that physicians reported they had performed, we identified the services State Fund paid to the surgical centers.

According to State Fund's management, it expects its upgrade of the bill review system to both promptly and fully implement the newly legislated fee schedule and associated rules.

Additionally, when no fee schedule exists for certain services, State Fund does not use its automated system to calculate payment levels for those services. Instead, bill reviewers calculate all payments to outpatient surgical facilities outside State Fund's medical bill review system and manually key summary information into the system. State Fund told us that it will continue to process all of its facility bills manually until it completes the implementation of a new bill review system, scheduled to have occurred by December 31, 2003. State Fund's management expects its upgrade of the bill review system to promptly and fully implement the newly legislated fee schedule and associated rules.

State Fund's management acknowledged that the manner in which State Fund currently collects and classifies its data, although not affecting the accuracy of its bill reviews or reimbursements, does not always allow for an extensive detailed analysis. Because State Fund inconsistently uses certain data elements, and because bill reviewers regularly aggregate the sometimes numerous payments to a provider for multiple services performed during a single visit and key them into the system using a single category, the cost information for some specific services is not individually available from the medical bill review system. The condition of the data prevented us from analyzing portions of State Fund's payments to surgical centers for the following reasons:

- State Fund's payment system did not always link its payments to surgical centers to the individual services it paid for. For example, State Fund sometimes pays facility fees for multiple procedures performed during a patient's single visit to a surgical center. However, the data did not tie the individual payments to the individual services State Fund paid for, preventing us from comparing the individual payment's price. This condition occurred in individual payments totaling $2.3 million (or 5 percent) of State Fund's total $43 million in payments to surgical centers.

- For payments totaling $11.8 million (or 27 percent) of State Fund's total $43 million in payments to surgical centers, the outpatient surgical procedure code we identified from State

Fund's data did not correspond to any of Medicare's nine ASC procedure group numbers. As we discussed previously, State Fund's data did not contain specific surgical codes that identified the procedures performed at surgical centers. As a result, we used the procedure codes from the physician's bill associated with the facility charge to identify the outpatient surgical procedure code. However, for this group of payments, we could not match the procedure code associated with the facility charges to a Medicare ASC procedure group number in order to compute the potential savings. Many of the codes we ultimately identified were related to the administration of medication by a physician—a service that does not qualify as a separate compensable surgical center charge under the Medicare ASC payment system rules.

- We could not identify the type of procedure performed in $12.2 million (or 28 percent) of State Fund's $43 million in payments to surgical centers because State Fund paid the facility fee in a different calendar year than it did the associated physician's fee. As a result, State Fund's database did not allow us to use the services that physicians performed to identify the facility service that State Fund paid for. Therefore, we could not determine which Medicare ASC procedure group these facility fees belonged in and could not compare State Fund's payment to a corresponding Medicare ASC fee. In mid-December 2003 State Fund's management asserted that, time permitting, the facility fees and physician fees can be linked across data sets. However, the files provided us for years prior to 2002 did not contain an important data field necessary to make this linkage. We agree we could have made this linkage if the bill review system files for years prior to 2002 provided us in June 2003 had contained a key data field for making this linkage that was contained in the 2002 bill review system files. Although unknown, if we possessed this key data field, we would anticipate that many of these payments could be analyzed while others could not because the facility fee would not match Medicare payment codes or multiple payments would not be specifically linked to the multiple procedures performed.

We could not identify the type of procedure being performed in 28 percent, or $12.2 million of the $43 million in surgical center payments because the facility fee was not paid in the same calendar year as the associated physician's fee.

- For payments we linked to surgical centers, totaling $2.3 million (or 5 percent) of State Fund's $43 million in payments to those facilities, we were unable to determine whether the payments were actually for a surgical center facility fee. As we discussed previously, because State Fund's payment data did not identify the type of facility it paid, we used a list of surgical centers that State Fund gave us

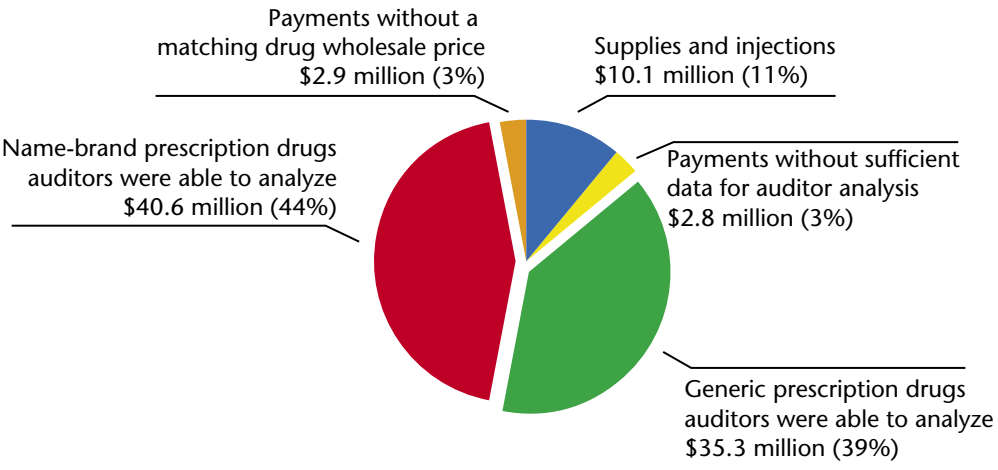
to differentiate payments it made to surgical centers from payments to other types of facilities. However, we found that other types of providers, such as physicians, also owned surgical centers and received payments for facility fees; in those cases, our methodology grouped payments to those providers for other services along with payments for surgical center facility services. Because of this aspect of State Fund's database design, we were unable to distinguish State Fund payments to physician-owned surgical centers for facility services from those for other types of medical services.

Because of these missing features in State Fund's data, we were unable to compute the savings that it could have realized from approximately $28.5 million (or 66 percent) of the $43 million in surgical center payments it made in 2002. However, based on the savings we identified from the payments to surgical centers that we were able to analyze, we believe it is likely that, had the reforms already been in place, significant savings would also have occurred in the payments we were unable to analyze.

We also encountered problems with State Fund's data on pharmaceutical payments. Figure 4 shows how we broke down the $91.7 million that State Fund paid for pharmaceuticals in 2002 into those we could analyze for savings and those we could not.

FIGURE 4

State Fund's Payments for Pharmaceuticals During 2002


Payments without a matching drug wholesale price $2.9 million (3%)
Supplies and injections $10.1 million (11%)
Name-brand prescription drugs auditors were able to analyze $40.6 million (44%)
Payments without sufficient data for auditor analysis $2.8 million (3%)
Generic prescription drugs auditors were able to analyze $35.3 million (39%)

Source: The State Compensation Insurance Fund's medical bill review file.

Although State Fund's medical bill review system identified payments State Fund made for pharmaceuticals totaling $91.7 million, in transactions worth more than $10 million (or 11 percent of the pharmaceutical payments State Fund made in 2002), the data indicated that the items purchased were for supplies or injections. Because the data precluded identifying where all the supplies and injections were administered, we were unable to determine if the new reforms would have applied to these items. Therefore, we did not include these payments in the comparison.

In addition, State Fund's bill reviewers inconsistently interpreted the data element indicating the quantity of a drug purchased. Further, some payments were for dispensed quantities so small that they caused us to question the accuracy of State Fund's data. Because of these inconsistencies and questionable data, we could not analyze $2.8 million of the amount State Fund paid for pharmaceuticals in 2002. In some instances, the bill reviewers incorrectly entered as the drug quantity purchased the package quantity from manufacturers or wholesale suppliers; or entered a code of 999, which the system reserves for a different data element altogether, the transaction type. These errors prevented us from calculating the average price State Fund paid for each drug and comparing that average price to the amount it would have paid for the same prescription drugs in the Medi-Cal payment system. In addition to finding these errors, we could not compute potential savings associated with drug payments totaling $2.9 million for which we could not match the identification codes—the national drug classification codes—in State Fund's data to the codes in the list of wholesale prices that Health Services provided us.

Although we identified the potential for significant savings through our comparative analysis of the amounts State Fund paid for surgical center facility services and the amounts it would have paid using the limits contained in the new legislative reforms, other aspects of the reforms will allow State Fund to realize additional savings.

THE PAYMENT SYSTEM THAT THE NEW LEGISLATION REQUIRES SHOULD PRODUCE SAVINGS IN ADDITION TO THOSE WE IDENTIFIED

Although we identified the potential for significant savings through our comparative analysis of the amounts State Fund paid for surgical center facility services and the amounts it would have paid using the limits contained in the new legislative reforms, other aspects of the reforms will allow State Fund to realize additional savings. Savings could increase because proper implementation of a Medicare-based fee schedule will set a firm ceiling for payments for surgical center facility

Savings could increase because proper implementation of a Medicare-based fee schedule will set a firm ceiling for payments for surgical center facility fees and should define the supplemental services that are compensated under a facility fee, thus reducing costly litigation and settlements that arise from ambiguities in the former system.

fees and should define the supplemental services that State Fund will now compensate under a facility fee, thus reducing costly litigation and settlements that arise from ambiguities in the former system. However, until the administrative director of the Division of Workers' Compensation (division) finalizes the rules associated with the new reforms, the magnitude of the savings that would come from bundling supplemental services, supplies, and drugs into the facility fee are impossible to predict. In addition, the Medicare-based fee schedule will also avoid the time and resources needed to contract for reasonable facility fees for outpatient surgical facilities or negotiate the payment levels for individual services.

Standardized billing and fee schedules will bring consistency and an upper limit to payments for what had been unregulated medical services, such as services performed at surgical centers, and will eliminate negotiations over individual billings. As we mentioned previously, in an effort to contain costs, State Fund staff has set a cap on payments for outpatient surgeries in hospitals and independent surgical centers (that is, those not associated with a PPO), at 200 percent of Medicare's payments for similar services. When State Fund uses its cap, the unpaid amounts that providers charged often result in disputes that require litigation to resolve. These hospitals and surgical centers usually file liens with the Workers' Compensation Appeals Board for the difference between their charges and State Fund's payments. The payment data included in the medical bill review files that State Fund provided us do not include the cost to settle disputed medical bills, payments made directly to injured workers, or cost containment expenses such as access fees paid to a PPO to gain access to a network of providers who perform medical services at negotiated rates. According to State Fund management, although recorded in other databases, this data is not available within the medical bill review database that houses payment data for medical service providers. State Fund's management told us that State Fund does not itemize or segregate the administrative costs of litigation related to surgical centers, nor does it separately itemize and track payments to settle liens in these cases in its medical bill review system. As a result, our analysis of data from the medical bill review system did not identify the additional savings State Fund will likely realize from adopting the Medicare-based payment system and eliminating these litigation costs, liens, and settlement payments in the future.

Our analysis of State Fund's payments indicated that it did not always adhere to its surgical center payment cap of 200 percent of Medicare's fee schedule. For 2002, we found that for 8 percent of the approximately 3,900 payments we analyzed, State Fund paid independent surgical centers solely for the use of the facility an average amount that exceeded 300 percent of the Medicare ASC rate, using the highest wage index in California. In fact, in one instance, State Fund paid a surgical center $13,705 when 120 percent of the corresponding Medicare ASC rate would have been only $631. Although we did not review the individual claim transactions to determine the cause for the higher payments, we expect that most of these instances will no longer occur once payments to surgical centers are limited to 120 percent of Medicare's rate.

Unlike surgical center facility fees under Medicare, California's payment system in 2002 required State Fund to pay surgical centers a reasonable fee for supplies, drugs, and other services connected with outpatient surgical procedures—in addition to the fee it paid for the use of the facility.

In addition, unlike surgical center facility fees under Medicare, California's payment system in 2002 required State Fund to pay surgical centers a reasonable fee for supplies, drugs, and other services connected with outpatient surgical procedures—in addition to the fee it paid for the use of the facility. We found a number of instances in which the amount State Fund paid to a surgical center for supplies, drugs, and other services that Medicare would normally bundle as part of the facility fee greatly exceeded the amount that State Fund paid for the facility fee alone. For example, State Fund paid one surgical center a facility fee of $1,126 and an additional $10,303 for drugs and supplies. Using a fee schedule based on 120 percent of Medicare's ASC payment system, State Fund would have paid no more than $631 for the same service. In another example, during 2002 State Fund paid a surgical center an average facility fee of $920 and separately paid the same surgical center an average additional amount of $12,721 for supplemental supplies; Medicare would allow a maximum payment hundreds of dollars less than the payment State Fund made for the use of the facility alone. These examples show the savings that could result from adopting the Medicare rules that bundle facility fees together with the supplemental services related to a single procedure into a single payment. However, until the administrative director finalizes the rules associated with the recent reforms, we cannot know how much, if any, of these supplemental payments State Fund might reduce or avoid altogether. For example, final rules could provide direction to State Fund on what is appropriate for compensating amounts such as the $11.8 million in facility fees that did not match Medicare procedure groups that we discussed in the previous section.

We also identified that during 2002, State Fund paid a PPO almost $27 million for bill review, care management, utilization services, and access to the PPO's network of contract providers. These payments are included in a cost containment file that is not part of the medical bill review system. State Fund uses a PPO network in an effort to better control medical costs by taking advantage of the contracts that the PPO network administrator has negotiated with individual providers. According to State Fund staff, the network access fee is based on savings achieved from using the PPO network. Under the outpatient fee schedule that the new legislation requires, State Fund management says that much of this almost $27 million could be avoided and added to potential savings. However, State Fund management said it cannot responsibly predict the extent of these potential savings. ■

CHAPTER 2

Savings Depend on the Careful Implementation of the Medical Payment Fee Schedules and Monitoring of the Medical Payment System

CHAPTER SUMMARY

Thorough implementation of the new legislative reforms will be key to realizing savings. Assuring a successful and uniform implementation of the Medicare ambulatory payment classification (APC) payment system for services from outpatient surgical facilities will depend on educating and guiding the workers' compensation community on the applicable rules for adapting Medicare's APC payment system to workers' compensation medical claims.[10] For example, uniformly implementing the service-bundling and pricing features of the Medicare APC payment system is central to preventing added costs for services performed and achieving all the savings the Legislature intended the reforms to provide. However, the administrative director for the Division of Workers' Compensation (division) in the Department of Industrial Relations stated that the State's hiring freeze and budget shortfalls have hampered his efforts to implement reforms.

Another aspect critical to fully implementing the reforms is having access to adequate and reliable medical payment data. Such data are necessary for two reasons: (1) to monitor the performance of the workers' compensation system in delivering quality care to injured workers at a reasonable cost to employers and (2) to track the effect of the reforms and other policy changes on the system's performance.

The division is currently developing a workers' compensation database, the Workers' Compensation Information System, that is intended to provide the level of information necessary to analyze and monitor system performance. However, as we

[10] Medicare uses the APC fee schedule, which has 569 procedure groups, to determine payments to hospitals for outpatient surgical procedures. However, legislative reforms that took effect January 1, 2004, uses the APC fee schedule to determine payments for outpatient surgical procedures that take place in a hospital or nonhospital setting.

concluded in our August 2003 report, this database, which eventually will collect workers' compensation injury and medical payment data from insurance companies (insurers) and claims administrators, has suffered extensive delays because of slow implementation, inadequate resources, and technical hurdles. As a result, we have serious reservations that—once the division can convince them to submit it—the information that insurers and claims administrators report will be of a quality necessary to permit the type of analysis and monitoring the division must carry out.

MEDICAL PAYMENT FEE SCHEDULES MUST BE PROPERLY IMPLEMENTED TO PRODUCE THE DESIRED SAVINGS

A properly implemented Medicare-based fee schedule for outpatient surgeries will produce savings. In fact, as we discussed in Chapter 1, a 2003 report by the Commission on Health and Safety and Workers' Compensation (commission) estimates that the workers' compensation system as a whole could save 41 percent of the 2004 costs for outpatient surgical facility services by adopting a fee schedule limiting payments for these services to 120 percent of Medicare's APC payment system, adjusted using an average wage index.

The law that took effect January 1, 2004 (Chapter 639, Statutes of 2003), requires the division's administrative director to adopt and periodically revise an official medical fee schedule that establishes reasonable maximum fees to be paid for a variety of services, including outpatient surgical facility services.

Using the State Compensation Insurance Fund (State Fund) medical payment data that we were able to analyze and a fee schedule equal to 120 percent of Medicare's ambulatory surgical center (ASC) payment method,[11] we calculated that, had the new legislative reforms been in effect during 2002, State Fund could have reduced the amount it paid for services from outpatient surgical facilities outside of a hospital setting (surgical centers) by 54 percent when adjusted by the index for geographic areas with the highest wage costs and by 61 percent when adjusted by the index for geographic areas with the lowest wage costs.

However, before the workers' compensation system can fully realize such savings, the new reforms must be properly implemented. Specifically, the law that took effect January 1, 2004 (Chapter 639, Statutes of 2003), requires the

[11] Medicare uses the ASC fee schedule, which has nine procedure groups, to determine payments for outpatient surgical procedures in outpatient surgical facilities outside of a hospital setting. However, legislative reforms that took effect January 1, 2004, uses the APC fee schedule to determine payments for outpatient surgical procedures that take place in a hospital or nonhospital setting.

division's administrative director to adopt and periodically revise an official medical fee schedule to establish reasonable maximum fees for a variety of services, including outpatient surgical facility services. The maximum payment the new law prescribes for these services cannot exceed 120 percent of Medicare's APC payment amount.[12] Although we used 120 percent of Medicare's ASC payment system for our analysis and the new legislation limits payments to surgical centers to 120 percent of Medicare's APC payment system, we believe that State Fund has paid for many outpatient surgical facility services that would not be covered had Medicare's APC payment system been in place.

In addition, both the Medicare APC and ASC payment systems include rules for bundling into a single payment the primary medical services the outpatient surgical facility provides along with supplemental facility services. Our analysis of payments that State Fund made to surgical centers during 2002 frequently identified services that would not be compensable under Medicare's rules. Also, in conducting our analysis of potential savings, we could not match the procedure code description in State Fund's data to a corresponding procedure group in the Medicare ASC fee schedule for payments totaling $11.8 million of the $43 million State Fund paid to surgical centers in 2002. Many of the codes we ultimately did identify related to services that Medicare's ASC rules do not regard as compensable charges. For that reason, the new legislation requires the division's administrative director to establish maximum fees for those items that Medicare does not cover, provided they do not exceed 120 percent of the fees that Medicare pays for services requiring comparable resources. However, if the administrative director is not prompt and diligent in providing the ongoing guidance needed to implement these reforms effectively, insurers may not fully realize the savings. As we discuss below, the administrative director stated that the State's hiring freeze and budget shortfalls have hampered his efforts to implement workers' compensation reforms.

Although allowable under the workers' compensation medical payment system at the time, our analysis of payments State Fund made to surgical centers during 2002 frequently identified that it paid for services that would not be compensable under Medicare's rules.

In late October 2003, we asked the division's administrative director how he planned to implement the new legislation's requirements, which were to become effective on

[12] In the emergency regulations proposed on December 30, 2003, by the administrative director of the workers' compensation program, the facility fees for outpatient surgical facilities are calculated at 122 percent of the Medicare APC fee schedule. The 2 percent in excess of the 120 percent of Medicare's fees required by new legislation is intended to compensate providers for more costly "outlier cases" in lieu of the Medicare calculation of payments for outlier cases, which requires determining cost-to-charge ratios for outpatient surgical facilities.

January 1, 2004. He indicated that he has made it a priority to give the public guidance on the new workers' compensation medical payment system requirements. He told us he was hoping to post information on the division's Web site as far in advance of January 1 as possible in order to guide the public to the appropriate Medicare and Medi-Cal materials. He further stated he expected he would need to develop regulations to interpret some of the provisions contained in the new statutes as he implements their changes in the medical payment system and that he was seeking the services of an expert on Medicare to assist in his efforts.

On December 30, 2003, the administrative director posted on the division's Web site a set of proposed emergency regulations to implement the medical fee schedules the new law requires. On the same day, the administrative director submitted the proposed regulations to the Office of Administrative Law for review and approval. These proposed regulations attempt to address the issues we identified relating to implementing the new payment system for surgical center services, including capping payments at fee schedule amounts and bundling into the facility fees the amounts that workers' compensation insurers would pay for supplemental drugs and supplies.

The emergency regulations proposed by the administrative director do not assure the permanent successful implementation of the workers' compensation payment system mandated by the new law.

However, the emergency regulations the administrative director proposed do not assure the permanent successful implementation of the workers' compensation payment system that the new law mandated. Assuming that the Office of Administrative Law accepts them as the division wrote them, the emergency regulations will remain in effect for only 120 days. Prior to their expiration, the administrative director must either provide permanent regulations, along with a statement that the regulations comply with all regular rule-making procedures, to the Office of Administrative Law or request that it approve the readoption of the emergency regulations. Therefore, the savings resulting from the payment system that the new law required will not be known until the regulations are finalized and approved by the Office of Administrative Law and the medical service providers (providers), insurers, and claims administrators who participate in the workers' compensation program interpret and implement them.

The administrative director pointed out that shortages in staffing and other resources continue to be an obstacle in implementing the new legislation's reforms as well as in implementing legislation from prior years. For example, although funding

The administrative director pointed out that shortages in staffing and other resources continue to be an obstacle in implementing the reforms required in this latest legislation, as well as in implementing legislation from prior years.

for 64 positions to implement the requirements contained in legislation that passed in 2002 (Chapter 6, Statutes of 2002), is included in the division's fiscal year 2003–04 budget, the administrative director stated that he cannot fill the positions until he is able to obtain an exemption to the State's current hiring freeze. In addition, the administrative director stated that the current year's budget does not include any funding to implement the reforms from the most recent legislation (Chapters 635 and 639, Statutes of 2003). According to the administrative director, there are no administrative means to obtain any additional funding in fiscal year 2003–04 to carry out the implementation of the new legislation, and the Legislature did not provide any funding in the enabling legislation. As a result, current staffing and funding limitations present a big challenge in promptly implementing the reforms.

THE DIVISION MUST RELY ON INSURERS FOR RELIABLE MEDICAL PAYMENT DATA

In our August 2003 report, we indicated that the division is developing an information system, the Workers' Compensation Information System (WCIS), to collect medical payment and other types of data from insurers and claims administrators to provide the division with useful and accessible information for overseeing the system and making necessary policy decisions. Such a data source could be useful for tracking the effects of policy and legislative changes to the workers' compensation program and allow the division to monitor and identify areas that may require additional legislation or regulation to further define program parameters to control costs and ensure access to care.

However, we also reported that the WCIS has been under development for years and was still unable to provide the medical payment data that could be useful to program evaluators or other decision makers. We concluded that the division had not assured us that the WCIS data would provide the detailed medical payment history the division would need to meet its oversight responsibilities and provide the statistical data for the research necessary to guide policy decisions. Although the division had identified the data elements it believed it needed to oversee the medical payment system, it was still negotiating in August 2003 the types of data elements that insurers, including State Fund, and claims administrators would report and the division would then use to analyze and monitor

medical payment transactions. According to the administrative director, once all the parties agree on the data elements the division will collect, data reporting will be mandatory.

During this review of the workers' compensation medical payment system, we found that the way in which State Fund collects and stores medical data limits their usefulness in monitoring the workers' compensation payment program. Although State Fund's management assured us this did not affect the accuracy of payments, we found that State Fund frequently provides incomplete data, maintains the data at a summary level without identifiers that would allow analysis at the transaction level, and uses a database design that makes certain detailed data review impossible. For example, State Fund's medical bill review system does not identify the specific medical procedure performed at a facility or the type of facility where the procedure was performed. In addition, the summary data entered into State Fund's system did not always include the specific identities and costs of individual pharmaceuticals and supplies that providers used in performing outpatient surgical procedures that, together with a fee for the use of the facility, composed the total payment to the providers. The division needs this type of information in order to analyze and monitor medical billing practices and their associated payments. In Chapter 1 we discuss more fully the types of challenges we encountered in attempting to analyze State Fund's data.

The division conducted a survey of seven insurers, which revealed that their databases, like State Fund's, appear to lack the ability to extract the detailed data called for, and in some cases, important data was not even collected.

The division conducted a survey of seven insurers, which revealed that their databases, like State Fund's, appear to lack the ability to extract the detailed data that the division called for; in some cases, the insurers reported that they did not even collect important data. By January 2003 the division had gathered the results of its survey and concluded that the sampled insurers could provide most of the 78 medical data elements that the division had proposed to collect. We present a summary of the division's survey in Appendix B. However, our analysis of the division's survey indicates that all seven insurers in the survey sample are collecting only seven of the 78 medical data elements. In addition, the survey respondents reported mixed efforts at collecting data for other important medical data elements. For example, only five of the seven respondents sampled reported that they collect the diagnosis-related group code, which identifies the treatment to address a worker's injury or illness. Furthermore, only four of the seven respondents reported that they collect facility codes, indicating the type of facility where medical treatment was provided. The division

believes that these data are useful for utilization reviews, audits, and statistical analysis. As a result, we have serious reservations that once the division can convince them to submit it, the information that insurers and claims administrators provide will be of a quality necessary to permit the type of analysis and monitoring the division must carry out.

RECOMMENDATIONS

To fully realize the savings from the new reforms to the workers' compensation medical payment system, the division's administrative director must continue to provide the workers' compensation community with the education and guidance that will ensure that new reforms are promptly and effectively implemented.

The division should ensure that the medical payment data it collects in the WCIS will provide the specific information the division needs to monitor the medical payments adequately and measure the effectiveness of policy decisions. Specifically, the division should clearly define the data elements it requires from insurers and claims administrators, and it should obtain the medical payment data using a standardized reporting instrument, which will ensure that insurers and claims administrators consistently and completely report the data so that it will be useful for the division's analysis and monitoring.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: January 27, 2004

Staff: Doug Cordiner, Audit Principal
Norm Calloway, CPA
Randal S. Russell

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APPENDIX A

State Fund Payments to Surgical Centers During 2002 Compared to 120 Percent of Medicare's Ambulatory Surgical Center Fee Schedule

The tables in this appendix compare the amounts the State Compensation Insurance Fund (State Fund) paid nonhospital outpatient surgical facilities (surgical centers) in 2002 to what State Fund would have paid for the same services if a fee schedule limited to 120 percent of Medicare's ambulatory surgical center (ASC) facility fee schedule had been in place. Medicare's ASC facility fee schedule consists of nine procedure groups. Each of these procedure groups represents outpatient surgical procedures that require a similar level of resources to perform. Medicare's ASC facility fee is also adjusted using a geographic wage index to compensate for the varying cost of providing the service in different geographic regions. Instead of applying one of the 25 different wage indexes used by Medicare in California to each payment, we used the lowest and highest state geographic wage indexes to present a range of potential savings. Therefore, each table consists of a subset labeled "Low End" representing California's lowest wage index and one labeled "High End" representing California's highest wage index. The source of the data is State Fund's medical bill review system.

Table A.1 on the following page represents payments to independent surgical centers—those that do not provide medical services under State Fund's agreement with a preferred provider organization (PPO). The savings presented in Table A.1 represent the difference between State Fund's actual payments to these independent surgical centers and the amount it would have paid using a limit of 120 percent of Medicare's ASC rates, broken down by procedure group. As we discussed in Chapter 1, we did not include a large portion of the payments to independent surgical centers in our price comparison analysis due to the limitations of State Fund's medical payment data. We calculated the savings in Table A.1 using $5.3 million, or 25 percent of the approximately $21 million in payments State Fund made to independent surgical centers during 2002.

TABLE A.1

Savings on Payments to Independent Surgical Centers in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings
Low End						
1	666	$ 875	$ 397	$ 583,076	$ 264,402	$ 318,674
2	895	1,230	532	1,100,625	476,140	624,485
3	1,158	1,472	609	1,704,073	705,222	998,851
4	986	1,535	752	1,513,318	741,472	771,846
5	83	1,504	856	124,839	71,048	53,791
6	0	NA	986	0	0	0
7	124	2,041	1,187	253,112	147,188	105,924
8	0	NA	1,161	0	0	0
9	0	NA	1,598	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,405,472**	**$2,873,571**
High End						
1	666	875	471	583,076	313,686	269,390
2	895	1,230	631	1,100,625	564,745	535,880
3	1,158	1,472	721	1,704,073	834,918	869,155
4	986	1,535	891	1,513,318	878,526	634,792
5	83	1,504	1,014	124,839	84,162	40,677
6	0	NA	1,168	0	0	0
7	124	2,041	1,407	253,112	174,468	78,644
8	0	NA	1,376	0	0	0
9	0	NA	1,894	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,850,505**	**$2,428,538**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.

Table A.2 represents surgical center services paid through State Fund's agreement with a PPO. State Fund has attempted to contain costs by contracting with a PPO that, in turn, has contracted with surgical centers to furnish services at negotiated rates. We calculated the savings in Table A.2 using $9.3 million, or 42 percent, of the approximately $22 million in payments State Fund made to surgical centers through the PPO during 2002. Again, limitations in the data discussed in Chapter 1 prevented us from analyzing all of the payments made through the PPO.

TABLE A.2

Savings on Payments to Surgical Centers Paid Through a Preferred Provider Organization in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings/(Loss)
Low End						
1	338	$ 963	$ 397	$ 325,576	$ 134,186	$ 191,390
2	1,212	1,212	532	1,468,917	644,784	824,133
3	1,592	2,236	609	3,559,788	969,528	2,590,260
4	1,419	2,036	752	2,888,690	1,067,088	1,821,602
5	147	2,297	856	337,587	125,832	211,755
6	1	1,016	986	1,016	986	30
7	267	2,506	1,187	669,095	316,929	352,166
8	8	1,855	1,161	14,839	9,288	5,551
9	0	NA	1,598	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,268,621**	**$5,996,887**
High End						
1	338	963	471	325,576	159,198	166,378
2	1,212	1,212	631	1,468,917	764,772	704,145
3	1,592	2,236	721	3,559,788	1,147,832	2,411,956
4	1,419	2,036	891	2,888,690	1,264,329	1,624,361
5	147	2,297	1,014	337,587	149,058	188,529
6	1	1,016	1,168	1,016	1,168	(152)
7	267	2,506	1,407	669,095	375,669	293,426
8	8	1,855	1,376	14,839	11,008	3,831
9	0	NA	1,894	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,873,034**	**$5,392,474**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.

Our analysis shows that the savings appear to be greater for the payments to surgical centers made through the PPO because of the different nature of these payments compared to the payments made to independent surgical centers. State Fund's payments to surgical centers through the PPO are at rates negotiated between the provider and the PPO and do not result in disputes between the parties over the appropriate payment for the services rendered. In contrast, in the absence of predetermined fees for outpatient surgical services, State Fund attempts to control costs charged by independent surgical

centers by unilaterally imposing limits on the fees it will pay them. According to State Fund's management, it has set a benchmark that caps payments at 200 percent of what Medicare would pay for a similar procedure. This cap may result in a dispute that can lead to additional payments. However, when State Fund makes additional payments to surgical centers to resolve disputes, it does not link those additional payments to the original claims in its medical bill review database. As a result, the payments State Fund ultimately makes to independent surgical centers may be even higher than the payments we analyzed from the medical bill review database because they do not include any additional payments already made or to be made to these providers to settle disputes that arise from State Fund's practice of capping these payments.

APPENDIX B

Results of the Division of Workers' Compensation Survey of Insurance Companies to Determine Available Medical Data

The Division of Workers' Compensation (division) in the Department of Industrial Relations is currently developing a workers' compensation database that is intended to provide the level of information necessary to analyze and monitor system performance. Although the division has identified the medical billing data elements that it believes it needs to monitor the medical payment system and conduct research, it is still working with insurers and claims administrators to determine what data elements they will ultimately submit to the Workers' Compensation Information System (WCIS).

Table B.1 on the following page shows the results of a May 2002 survey of seven insurers in which the division and its WCIS Advisory Committee asked insurers about the practicality of collecting 78 selected medical data elements. By January 2003, the division had gathered the results of the survey and concluded that the sampled insurers could provide most of the medical data elements that the division proposed to collect. However, as we discuss in Chapter 2, we question whether the collection of these data will be sufficient to meet the intended objectives for the WCIS because of the inconsistencies in the data reported as being collected. Our analysis of the survey results indicates that only seven of the 78 medical data elements are being collected by all of the insurers in the sample. Hence, we have serious reservations that, once the division can convince them to submit it, the information reported by insurers and claims administrators will be of a quality necessary to permit the type of analysis and monitoring needed.

TABLE B.1

Division of Workers' Compensation Survey of Insurers

Data Element Number	Data Description	Data Element Collected?		No Response
		No	Yes	
5	**Jurisdictional claim number**	**0**	**7**	**0**
14	Claim administrator mailing postal code	1	5	1
15	Claim administrator claim number	1	5	1
31	**Date of injury**	**0**	**7**	**0**
187	Claim administrator federal employer identification number	1	5	1
188*	Claim administrator name	1	4	1
208	Managed care organization identification number	3	3	1
209	Managed care organization name	2	4	1
501	**Total charge per bill**	**0**	**7**	**0**
502*	Billing type code	2	4	0
504	Facility type code (inpatient or outpatient)	3	4	0
507	Provider agreement code	4	3	0
508	Code indicating the reason for bill submission/resubmission	3	4	0
509	**Service bill date(s) range**	**0**	**7**	**0**
510	Date of bill	1	6	0
511	**Date insurer received bill**	**0**	**7**	**0**
512	Date insurer paid bill	0	6	1
513	Admission date	2	5	0
514	Discharge date	2	4	1
516	Total amount paid for bill	0	6	1
518	Diagnostic related group code	2	5	0
521	Principle diagnosis code	1	6	0
522	Clinical modification diagnosis code	1	6	0
524	Date procedure performed	1	6	0
527	Date prescription billed	2	5	0
528	Billing provider/group name	1	6	0
534	Gatekeeper indicator	5	1	1
535	Admitting diagnosis code	1	6	0
537	Billing provider primary specialty code	2	5	0
542	Billing provider postal code	1	6	0
544	Bill adjustment reason code	2	5	0
547	Bill line number	1	6	0
552	Total service charge per line item	1	5	1
557	Diagnosis code(s)	2	5	0
561	Prescription line number	4	3	0
563	Drug name	2	5	0
564	Cost basis determination code	5	2	0
565	Total per line rental charge	3	4	0
566	Purchase price of durable medical equipment	3	4	0
567	Billing frequency for durable medical equipment	6	0	1

Data Element Number	Data Description	Data Element Collected?		No Response
		No	Yes	
570	Drugs/supplies quantity dispensed	1	6	0
571	Drugs/supplies number of days	5	1	1
572	**Drugs/supplies billed amount**	**0**	**7**	**0**
574	Total amount paid per line	1	5	1
579	Drugs/supplies dispensing fee	4	2	1
586	Entity providing care federal employer identification code	2	4	1
589	Name of entity providing care	2	5	0
595	Specialty code of entity providing care	2	5	0
599	State license number of entity providing care	3	4	0
600	Place where service performed	1	5	1
604	Date prescription filled	1	6	0
624	Initial amount paid	0	6	1
626	Principal procedure billed code	1	5	1
629	Billing provider identifier code	1	6	0
630	Billing provider state license number	3	4	0
638	Name of group/entity providing all services on this bill	1	6	0
642	Federal employer identification number for group/entity rendering this bill	1	6	0
643	State license number of group/individual rendering this bill	3	4	0
649	Specialty license number of group/entity rendering this bill	5	1	1
651	Primary specialty code of group/entity rendering this bill	2	5	0
678	**Facility name**	**0**	**7**	**0**
679	Facility federal employer identification number	1	6	0
680	Facility state license number	3	3	1
681	Facility Medicare number	3	4	0
688	Facility postal code	1	6	0
704	Managed care organization federal employer identification number	3	3	1
712	Managed care organization postal code	2	4	1
715	Jurisdictional procedure code billed	3	4	0
717	Billed procedure code modifier	2	5	0
718	Jurisdictional modifier for procedure billed code	4	3	0
721	National drug code billed	2	5	0
726	Procedure paid code	1	6	0
727	Paid procedure code modifier	1	6	0
728	National drug code paid	1	5	1
729	Jurisdictional procedure paid code	2	5	0
730	Jurisdictional modifier for procedure paid code	3	4	0
732	Code indicating reason service adjustment made	2	5	0
737	Bill procedure code	2	5	0
Totals		**147**	**373**	**24**

Source: The Department of Industrial Relations' Division of Workers' Compensation.

Note: Lines shown in bold indicate the seven data elements (out of a possible 78) that all seven surveyed insurers collect.

* One of the seven insurers surveyed was not asked to respond regarding this data element.

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Agency's comments provided as text only.

State Compensation Insurance Fund
1275 Market Street
San Francisco, CA 94103-1410

January 12, 2004

Elaine M. Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

The State Compensation Insurance Fund was approached in connection with the charge given the Bureau of State Audits by the Joint Legislative Audit Committee to study costs, and in particular to study medical costs within the workers' compensation system. On August 27, 2003, the Bureau of State Audits issued your report entitled **"California Workers Compensation Program: *The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care"***.

The charge to the Bureau of State Audits was a review of the workers compensation system. We were given assurance by the Bureau of State Audits that this was not an examination of the State Fund. The results of this audit cannot be viewed as an audit of the State Fund, our data systems, our claims or payments processes. The State Fund's involvement in this audit was voluntary. The State Fund was asked to participate in order to identify data from our databases that the Bureau of State Audits believed would be helpful in completion of your tasks. To our knowledge no other underwriter of workers compensation insurance was approached to assist the Bureau of State Audits in this endeavor. The State Fund agreed to fully participate and voluntarily allow full access to our databases with regard to this assignment in order to further your work in what we regarded to be a significant public policy examination of the workers compensation system. However in providing access to the Bureau of State Audits, at all times, the identities of injured workers and their medical information were maintained in strict confidence and were never disclosed.

Over the past six months the State Fund has met with and provided data to the Bureau of State Audits on numerous occasions. Our staff and consultants have spent many hundreds of hours to provide answers and data to the Bureau of State Audits. We congratulate the Bureau of State Audits on the professionalism and the quality of your August 27, 2003 report. Many of your findings are consistent with the legislative intent for workers compensation reform found in the recently passed AB 227 and SB 228. We, at the State Fund believe our unique cooperation in your study contributed to the fuller understanding of the need for effective workers compensation reform.

* California State Auditor's comment appears on page 53.

The State Fund databases are constructed in a manner that is consistent with the current state of the art within the workers compensation industry. However, the process of using a workers compensation carrier's large medical and compensation databases for public policy research is very labor intensive and demanding. The issues encountered by the Bureau of State Audits are consistent with the experience of others such as the California Workers Compensation Institute, Workers Compensation Insurance Rating Bureau and the Workers Compensation Research Institute who regularly aggregate workers compensation carrier data.

The State Fund's databases were designed to allow the State Fund to carry out our mission to provide workers compensation coverage to California employers and to provide those benefits due to their injured employees under California's workers compensation law. Our databases were not designed for public policy research purposes. As we recognize the importance of accurate information to further research and study of the workers compensation system we provide data as well as financial and manpower support to the California Workers Compensation Institute, the Workers Compensation Insurance Rating Bureau and the Workers Compensation Research Institute. Our data has been consistently and successfully used by each organization in their studies and reports.

State Fund databases are fully sufficient to the task of making and recording accurate compensation and medical benefit payments. Difficulties encountered in completing public policy research must be differentiated from the process of making accurate benefit payments. We are currently implementing two major claims systems development initiatives. Upon completion of these initiatives we will realize a number of business efficiencies. These improvements will include improved data capture at the detail level that, while not altering reimbursement amounts, will further increase the value of the data for research analysis purposes.

The State Fund appreciates and congratulates the Bureau of State Audits for your contributions to the understanding of the depth of the failure of the workers compensation system in California to adequately insure appropriate health care for injured workers at an affordable cost to California employers. The enactment of AB 227 and SB 228 was a positive step in the right direction. The State Fund looks forward to the opportunity to work with the administration and the legislature to make the improvements still required in our workers compensation system.

Sincerely,

(Signed by: Lisa Middleton)

Lisa Middleton
Claims/Rehabilitation Manager

COMMENT

California State Auditor's Comment on the Response From the State Compensation Insurance Fund

To provide clarity and perspective, we are commenting on the State Compensation Insurance Fund's (State Fund) response to our audit report. The number below corresponds to the number we placed in the margin of State Fund's response.

● While we appreciate the cooperation shown by State Fund staff in providing the data we requested for this audit, because State Fund is a publicly created entity our statutes provide for full access to such data.

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Agency's comments provided as text only.

California Labor and Workforce Development Agency
801 K Street, Suite 2101
Sacramento, CA 95814

January 12, 2004

Elaine M. Howle, State Auditor
Bureau of State Audits
555 Capitol Mall
Sacramento, CA 95814

Dear Ms. Howle:

The Labor and Workforce Development Agency (Labor Agency), as part of its oversight of the Department of Industrial Relations (DIR), Division of Workers' Compensation (DWC), reviewed the draft report of the Bureau of State Audits (BSA) titled *California's Workers' Compensation Program: Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis* (Report 2003-108.2).

The purpose of the audit was to assess the amount of medical savings that may be achieved as a result of new medical fee schedules for outpatient surgery centers and pharmaceuticals, pursuant to workers' compensation reforms that were included in Senate Bill 228 (Alarcon) (Chapter 639, Statutes of 2003).

Senate Bill 228 significantly revised the existing medical payment system by repealing the existing Official Medical Fee Schedule language in Labor Code § 5307.1 and replacing it with new language that provides, as of January 1, 2004, for reimbursement of pharmaceuticals at 100 percent of the Medi-Cal rate, inpatient hospital reimbursement at 120 percent of the Medicare rate, and hospital outpatient and ambulatory surgery center reimbursement at 120 percent of the Medicare rate.

BSA discovered there were some limitations in the data made available by State Compensation Insurance Fund (SCIF) for use in the analysis. SCIF's data was not designed for these research purposes; however, by making their data available and assisting BSA in manipulating the data, SCIF made it possible to complete this analysis and make information available to policymakers and the workers' compensation community overall.

BSA concludes that if the new fee schedules had been in effect in 2002, SCIF could have saved between 54 and 61 percent of the billings it paid for surgical center facility fees and could have saved 24 percent of the billings it paid for prescription drugs. In addition, SCIF's costs to litigate medical claims and to provide medical cost containment services may be reduced since use of a mandatory fee schedule should reduce disputes. However, BSA states that it cannot reliably conclude that these savings reflect the savings possible in the entire population of SCIF payments, due to data limitations.

BSA recommends that DWC continue to provide the workers' compensation community with the education and guidance that will ensure that the reforms are promptly and effectively implemented. In addition to promulgating emergency fee schedule regulations (effective 1/2/04) and making Medi-Cal payment rates available on its website, DWC is conducting educational conferences in both Northern and Southern California and keeping the workers' compensation community apprised through an electronic newsline. Although the current regulations are emergency regulations that will remain in effect for 120 days, DWC expects the final regulations to closely mirror those already in effect.

The BSA report emphasizes the importance of having adequate data that will allow policymakers to make system changes that will have the potential for enormous savings. The findings highlight the fact that it is likely that carriers do not currently collect and maintain data sufficient for policy research purposes. The adoption of standardized billing forms and electronic billing will be a key component of facilitating the data collection needed for policy decisions. While these changes may entail some initial costs for the payer and provider community, they will also bring substantial efficiencies and overall reduction in costs. BSA recommends that DWC ensure that the medical payment data it collects in its Workers' Compensation Information System (WCIS) provides the specific information it needs to adequately monitor medical payments for the effectiveness of policy decisions. Keeping in mind that the Administration's overall goal is to reduce costs, DWC is working with insurers and claims administrators to develop a cost-neutral method to transmit electronic medical payment information to the WCIS. A policy committee comprised of both payers and providers is working to answer the policy and logistical questions posed by collecting consistent information from approximately 600 different payers in the workers' compensation system. DWC will be working with payers and providers to develop standardized electronic billing forms, which would allow the data elements to accompany the billing, relieving the payer from the necessity to re-enter the information in a different data format.

As confirmed by this audit, the reforms in the 2003 workers' compensation reform package will provide some cost relief to California's employers. However, workers' compensation costs in California still remain the highest in the nation. On November 17, 2003, Governor Schwarzenegger called the Legislature into a special session on workers' compensation and proposed a reform package that builds on the reforms enacted in AB 227/SB 228. Two major elements of the Governor's proposed reforms would further address medical costs in the workers' compensation system: using proven methods of delivering medical care so that injured workers receive faster, more consistent treatment; and providing the option of "Door-to-Door" coverage so that employers can maximize the benefits of the group health model, while ensuring adequate coverage to employees. As the Legislature debates the Governor's proposed reforms, DWC will continue to work to fully implement the 2003 reforms and the other programs described in this letter.

Sincerely,

(Signed by: Victoria L. Bradshaw)

Victoria L. Bradshaw
Undersecretary
Labor and Workforce Development Agency

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press

California State Auditor

BUREAU OF STATE AUDITS

California's Workers' Compensation Program:

Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis

Presentation by

California State Auditor

Conference Committee on Workers' Compensation

February 26, 2004

This presentation document is only intended to outline selected portions of Report 2003-108.2, *Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis* (January 2004). For a more complete explanation of the points outlined in this document, refer to the report.

CONTENTS

Audit Scope

Background Information 1

Analyses Performed 3

Audit Highlights

Recent Reforms Will Cause Payments for Outpatient Surgical Facility Services and Prescription Drugs to Drop Sharply 5

Savings Depend on Careful Implementation of the Medical Payment Fee Schedules and Monitoring of the Medical Payment System 10

Recommendations 12

Attachment

Table A.1 13

Table A.2 14

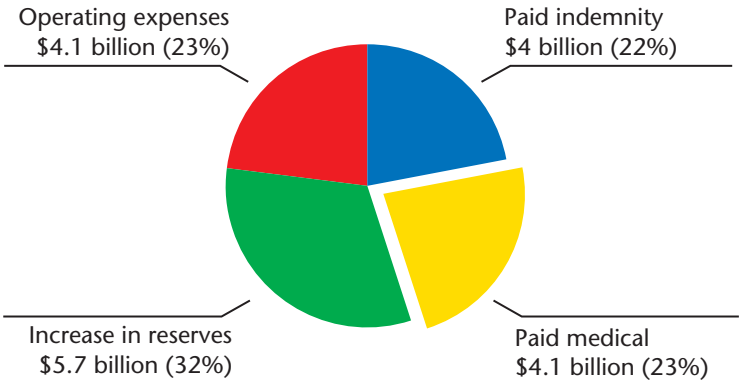
AUDIT SCOPE

BACKGROUND INFORMATION

The Workers' Compensation Insurance Rating Bureau (rating bureau) reported that insurers paid workers' compensation costs of more than $17.9 billion in 2002, with medical costs representing $4.1 billion.

FIGURE 1

Insurers' California Workers' Compensation Costs for 2002*



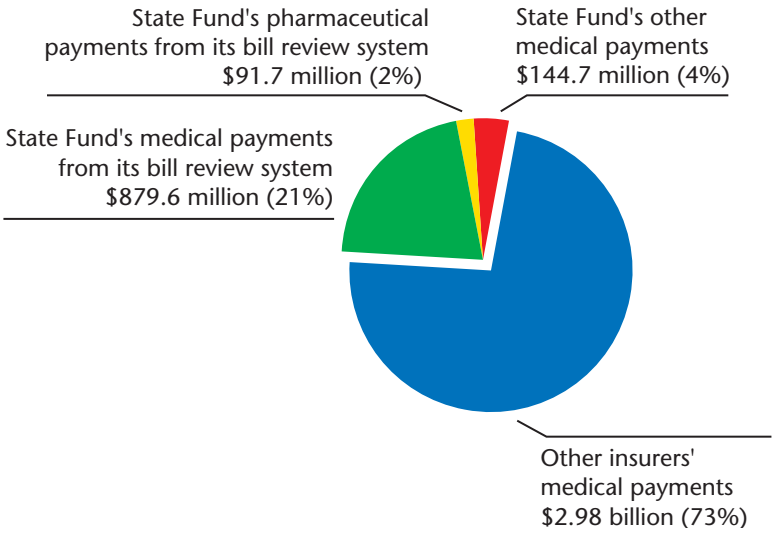
Source: The Workers' Compensation Insurance Rating Bureau's 2002 Annual Report.

* Total costs for insurers were over $17.9 billion. Some large, stable, or government employers may pay for employees' benefits directly through self-insurance.

Figure 2 shows the paid medical costs State Fund reported to the rating bureau compared to other insurers.

FIGURE 2

Comparison of Medical Payments Reported by State Fund and Other California Workers' Compensation Insurers in 2002*


State Fund's pharmaceutical payments from its bill review system $91.7 million (2%)
State Fund's other medical payments $144.7 million (4%)
State Fund's medical payments from its bill review system $879.6 million (21%)
Other insurers' medical payments $2.98 billion (73%)

Source: The Workers' Compensation Insurance Rating Bureau and the State Compensation Insurance Fund.

* Medical payments by all insurers totaled $4.1 billion.

Of the $880 million State Fund paid in medical payments, $203 million was paid to health care facilities in 2002. Payments to these facilities are broken out as follows:

- $56 million to physical rehabilitation facilities.
- $34 million to inpatient hospital facilities when the procedure required an overnight stay.
- $70 million to outpatient surgical facilities in hospitals.
- $43 million to surgical centers when they perform outpatient surgeries.

ANALYSES PERFORMED

- Specific focus of this audit was on the $43 million State Fund paid to surgical centers and the $91.7 million it paid for drugs in 2002. These amounts make up 12 percent of State Fund's total medical costs for that year.

- Requested data from State Fund because it paid 27 percent of all workers' compensation medical costs related to insured employers in 2002.

- Analyzed payments State Fund made to surgical centers and for pharmaceuticals that were included in its medical bill review system in 2002.

- Calculated potential savings of recent reforms using 120 percent of Medicare's Ambulatory Surgical Center (ASC) fee schedule.

- Used ASC fee schedule, which has nine groups, rather than Ambulatory Payment Classification schedule because it has 569 groups.

- Compared State Fund's average payments for prescription drugs in 2002 to the amount California's Medi-Cal program would have paid for the same drugs.

- Determined the Division of Workers' Compensation (division) plans for implementing the new legislation's fee schedule requirements and completing its data collection system, the Workers' Compensation Information System (WCIS).

AUDIT HIGHLIGHTS

- Of the $14.5 million in surgical center payments that we analyzed, State Fund would have saved between $7.8 million to $8.9 million in 2002 had the recent reforms been in place.

- Savings for surgical centers represent about 54 percent to 61 percent, respectively, of the payments in State Fund's medical bill review database that contained sufficient detail for analysis.

- Of the $76 million in pharmaceutical payments that we analyzed, State Fund would have saved $18 million[1] in 2002 had the new reforms been in place during that year.

- Our analysis was limited because the data entered into State Fund's medical bill review file were often incomplete.

- Achievement of savings will depend upon careful implementation of newly legislated reforms.

- The administrative director of the division states that his efforts to implement reforms have been hampered by hiring freezes and budget shortfalls.

- The division continues to lack a comprehensive database to monitor workers' compensation medical payments.

[1] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments effective January 1, 2004, which a preliminary injunction partially blocked. Without the 5 percent reduction, savings are estimated at $14.6 million.

Recent Reforms Will Cause Payments for Outpatient Surgical Facility Services and Prescription Drugs to Drop Sharply

New reforms limit payments for the use of outpatient surgical facilities (facility fees) to 120 percent of Medicare's ambulatory payment classification fee schedule. The reforms also limit payments for pharmaceuticals to 100 percent of the relevant Medi-Cal fee schedule.

OUR REVIEW OF ACTUAL STATE FUND PAYMENTS TO SURGICAL CENTERS SHOWS THE POTENTIAL FOR SAVINGS

Our analysis indicates that had similar reforms been in place during 2002, State Fund could have saved anywhere from $7.8 million to $8.9 million of the $14.5 million paid to outpatient surgical centers we were able to analyze.

> This represents a range of 54 percent to 61 percent, respectively. Our results are similar to the Commission on Health and Safety and Workers' Compensation's projection that the system would save 66 percent on payments for surgical center facility services.
>
> The range reflects an adjustment using the geographic index for the highest and lowest cost areas in California.

We were able to analyze only $14.5 million (or 34 percent) of the $43 million in identifiable payments that State Fund made to surgical centers in 2002. Our analysis was limited because:

1) The medical payment data were incomplete, inconsistent, or too general.

2) Features of the database design made detailed data analysis impossible.

State Fund makes payments to two types of surgical centers: (1) independent surgical centers and (2) surgical centers that contract with a preferred provider organization (PPO) that in turn provides services through its network of medical service providers at negotiated rates.

> **Tables A.1 and A.2 (attached)** show savings for payments to independent surgical centers and through a PPO respectively.
>
> State Fund could have saved between $2.4 million and $2.9 million in payments to the independent surgical centers and between $5.4 million and $6 million in payments through a PPO if the recent reforms had been in place during 2002.

Savings appear to be greater for the payments associated with the PPO because the rates are negotiated and, therefore, do not result in disputes.

In contrast, in the absence of predetermined rates for outpatient surgical centers, State Fund attempts to control costs by unilaterally imposing limits on the fees it pays. According to State Fund it caps payments at 200 percent of Medicare's rates for similar services. In some cases this cap results in disputes that can lead to additional payments. However, when State

Fund makes the additional payments it does not link those payments to the original claims in its medical bill review database. As a result, the payments State Fund ultimately makes to independent surgical centers may be even higher.

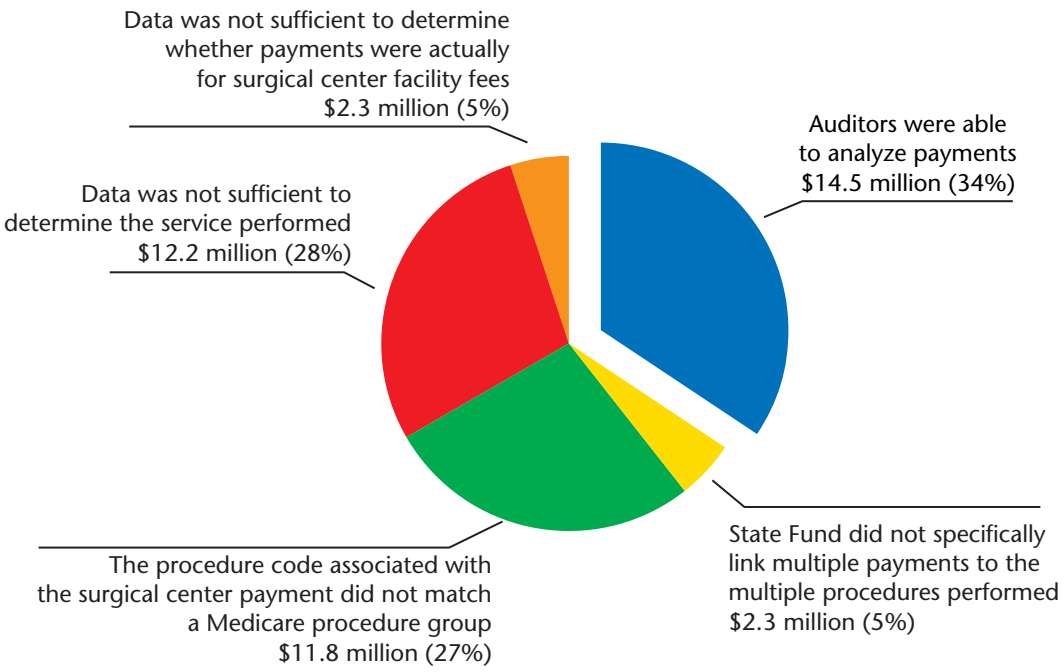
THE CONDITION OF THE MEDICAL PAYMENT DATA LIMITED OUR ANALYSIS

Using the medical payment data included in State Fund's bill review system, we attempted to analyze the approximately $43 million we were able to identify as payments to outpatient surgical centers. However, due to various problems with these data, we were able to analyze just over $14.5 million of the $43 million (or 34 percent).

Figure 3 shows the portions of those payments that we could analyze and those we could not because of problems with State Fund's data.

FIGURE 3

Only a Portion of State Fund's Payment Data for Surgical Centers During 2002 Could Be Analyzed*


Data was not sufficient to determine whether payments were actually for surgical center facility fees $2.3 million (5%)
Auditors were able to analyze payments $14.5 million (34%)
Data was not sufficient to determine the service performed $12.2 million (28%)
The procedure code associated with the surgical center payment did not match a Medicare procedure group $11.8 million (27%)
State Fund did not specifically link multiple payments to the multiple procedures performed $2.3 million (5%)

Source: The State Compensation Insurance Fund's medical bill review file.

* Segments total $43.1 million. We rounded this amount to $43 million when discussing it throughout the report.

Breakdown of the $43 million is as follows:

- $14.5 million—Payments we were able to analyze.
- $12.2 million—Data was not sufficient to determine the service performed.

- $11.8 million—The procedure code did not match a Medicare procedure code.
- $2.3 million—State Fund did not specifically link multiple payments to the multiple procedures performed.
- $2.3 million—Data was not sufficient to determine whether payments were for surgical center facility fees.

POTENTIAL SAVINGS ALSO EXIST IN PHARMACEUTICALS

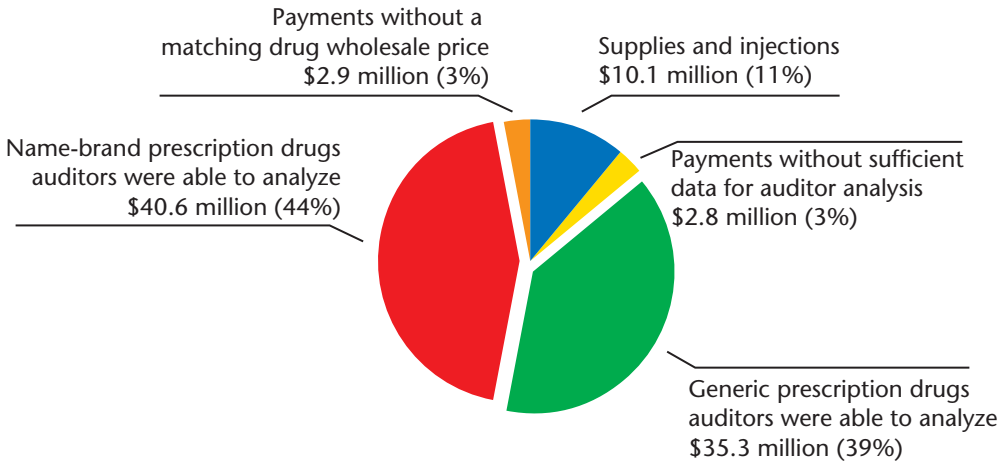
State Fund could have saved another $18 million (or about 24 percent) on the amount it spent on prescription drugs.[2]

State Fund could have saved $6.2 million, or 15 percent, on name-brand prescription drugs and $11.8 million, or 33 percent, on generic prescription drugs in 2002.

STATE FUND'S PAYMENTS FOR PHARMACEUTICALS DURING 2002

FIGURE 4

State Fund's Payments for Pharmaceuticals During 2002


Payments without a matching drug wholesale price $2.9 million (3%)
Supplies and injections $10.1 million (11%)
Name-brand prescription drugs auditors were able to analyze $40.6 million (44%)
Payments without sufficient data for auditor analysis $2.8 million (3%)
Generic prescription drugs auditors were able to analyze $35.3 million (39%)

Source: The State Compensation Insurance Fund's medical bill review file.

[2] Savings are based on a formula that includes a 5 percent reduction in Medi-Cal payments; however, a preliminary injunction partially blocked the reduction. Without the 5 percent reduction, savings are estimated at $14.6 million (19 percent).

State Fund paid $91.7 million for pharmaceutical purchases in 2002. Of this amount:

- $75.9 million was for prescription drugs that appear on a list of drug wholesale prices that the Department of Health Services uses in administering its Medi-Cal program.

- $10.1 million was for supplies and injections that we could not verify would be affected by the new reforms.

- $2.8 million was for items for which data did not allow further analysis.

- $2.9 million was for drugs whose names did not appear on the list of drug wholesale prices.

Of the approximately $76 million State Fund paid for prescription drugs, $41 million was for name-brand drugs and $35 million was for generic drugs.

We based our comparison on the most commonly used payment, adjusted for the January 1, 2004, Medi-Cal reduction—the average wholesale price less 10 percent—plus a $3.55 dispensing fee, less an additional 5 percent.

THE PAYMENT SYSTEM THAT THE NEW LEGISLATION REQUIRES SHOULD PRODUCE SAVINGS IN ADDITION TO THOSE WE IDENTIFIED

- Savings could increase because proper implementation of a Medicare-based fee schedule will set a firm ceiling for payments for surgical center facility fees and should define the supplemental services that State Fund will now compensate under the facility fee.

  For 2002, we found that for 8 percent of the approximately 3,900 payments we analyzed, State Fund paid independent surgical centers solely for the use of the facility an average amount that exceeded 300 percent of the Medicare ASC rate, using the highest wage index in California.

  Although we did not review the individual claim transactions to determine the cause for the higher payments, we expect that most of these instances will no longer occur once payments to surgical centers are limited to 120 percent of Medicare's rate.

- Unlike surgical center facility fees under Medicare, California's payment system in 2002 required State Fund to pay surgical centers a reasonable fee for supplies, drugs, and other services connected with outpatient surgical procedures—in addition to the fee it paid for the use of the facility.

- We found a number of instances in which the amount State Fund paid for supplies, drugs, and other services that Medicare would normally bundle as part of the facility fee, greatly exceeded the amount State Fund paid for the facility fee alone.

  For example, State Fund paid one surgical center a facility fee of $1,126 and an additional $10,303 for drugs and supplies. Using a fee schedule based on 120 percent of Medicare's ASC payment system, State Fund would have paid no more than $631 for the same service.

- Costly litigation and settlements that arise from ambiguities in the former system should be reduced under the new system.

- According to State Fund, under the outpatient fee schedule that the new legislation requires, much of the $27 million it paid to a PPO to control costs could be avoided and added to potential savings.

  In 2002, State Fund paid a PPO almost $27 million for bill review, case management, utilization services, and access to the PPO's network of contract providers.

Savings Depend on Careful Implementation of the Medical Payment Fee Schedules and Monitoring of the Medical Payment System

Uniformly implementing the service-bundling and pricing features of the Medicare Ambulatory Payment Classification (APC) payment system is central to preventing added costs for services performed and achieving all the savings the Legislature intended the reforms to provide.

New law requires the Division of Workers' Compensation's (division) administrative director to adopt and periodically revise an official medical fee schedule that establishes reasonable maximum fees to be paid for a variety of services including outpatient surgical facility services.

- On December 30, 2003, the administrative director posted on the division's Web site a set of proposed emergency regulations to implement the medical fee schedules the new law requires.

- On the same day, the administrative director submitted the proposed regulations to the Office of Administrative Law for review and approval. If approved, the emergency regulations will remain in effect for only 120 days.

- However, the division's administrative director stated that the State's hiring freeze and budget shortfalls have hampered his efforts to implement past and current reforms.

- Although funding for 64 positions is included in the division's fiscal year 2003-04 budget to implement reforms that took effect in 2002, the administrative director stated that he cannot fill the positions until he is able to obtain an exemption to the State's current hiring freeze.

- The 2003-04 budget does not include any funding to implement the reforms that took effect in January 2004.

Another aspect critical to fully implementing the reforms is having access to adequate and reliable medical payment data.

Such data is necessary for two reasons: (1) to monitor the performance of the workers' compensation system in delivering quality care to injured workers at a reasonable cost to employers and (2) to track the effect of the reforms and other policy changes on the system's performance.

The division is currently developing a workers' compensation database that is intended to provide the level of information necessary to analyze and monitor system performance. However, this database has suffered extensive delays because of slow implementation.

THE DIVISION MUST RELY ON INSURERS FOR RELIABLE MEDICAL PAYMENT DATA

The division is developing a Workers' Compensation Information System (WCIS), to collect medical payment and other types of data from insurers and claims administrators.

However, WCIS has been under development for years and is still unable to provide the medical payment data that could be useful to program evaluators and decision makers.

Although the division had identified the data elements it believed it needed to oversee the medical payment system, it was still negotiating in August 2003 the types of data elements that insurers, including State Fund, and claims administrators would report.

The division conducted a survey of seven insurers which revealed that their databases, like State Fund's, appear to lack the ability to extract the detailed data that the division called for; in some cases the insurers reported that they did not even collect important data.

Of the 78 medical data elements that the division had proposed to collect, only seven elements were being collected by all the insurers in the division's survey.

RECOMMENDATIONS

To fully realize the savings from the new reforms to the workers' compensation medical payment system, the division's administrative director must continue to provide the workers' compensation community with the ongoing education and guidance that will ensure the reforms are promptly and effectively implemented.

The division should ensure that the medical payment data it collects in the WCIS provides the specific information the division needs to adequately monitor medical payments for compliance with the payment system and to measure the effectiveness of policy decisions.

> The division needs to clearly define the data elements it requires from insurers and claims administrators. It should obtain medical payment data using a standardized reporting instrument that will ensure that insurers and claims administrators consistently and completely report the data in such a way that it will be useful for the division's analysis and monitoring.

Attachments (Tables A.1 and A.2)

TABLE A.1

Savings on Payments to Independent Surgical Centers in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings
Low End						
1	666	$ 875	$ 397	$ 583,076	$ 264,402	$ 318,674
2	895	1,230	532	1,100,625	476,140	624,485
3	1,158	1,472	609	1,704,073	705,222	998,851
4	986	1,535	752	1,513,318	741,472	771,846
5	83	1,504	856	124,839	71,048	53,791
6	0	NA	986	0	0	0
7	124	2,041	1,187	253,112	147,188	105,924
8	0	NA	1,161	0	0	0
9	0	NA	1,598	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,405,472**	**$2,873,571**
High End						
1	666	875	471	583,076	313,686	269,390
2	895	1,230	631	1,100,625	564,745	535,880
3	1,158	1,472	721	1,704,073	834,918	869,155
4	986	1,535	891	1,513,318	878,526	634,792
5	83	1,504	1,014	124,839	84,162	40,677
6	0	NA	1,168	0	0	0
7	124	2,041	1,407	253,112	174,468	78,644
8	0	NA	1,376	0	0	0
9	0	NA	1,894	0	0	0
Totals	**3,912**			**$5,279,043**	**$2,850,505**	**$2,428,538**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.

TABLE A.2

Savings on Payments to Surgical Centers Paid Through a Preferred Provider Organization in 2002

Medicare Procedure Group	Number of Facility Fees Paid	Average State Fund Payment	120 Percent of Medicare ASC Rate	Total State Fund Paid	Amount Medicare Would Have Paid	Savings/(Loss)
Low End						
1	338	$ 963	$ 397	$ 325,576	$ 134,186	$ 191,390
2	1,212	1,212	532	1,468,917	644,784	824,133
3	1,592	2,236	609	3,559,788	969,528	2,590,260
4	1,419	2,036	752	2,888,690	1,067,088	1,821,602
5	147	2,297	856	337,587	125,832	211,755
6	1	1,016	986	1,016	986	30
7	267	2,506	1,187	669,095	316,929	352,166
8	8	1,855	1,161	14,839	9,288	5,551
9	0	NA	1,598	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,268,621**	**$5,996,887**
High End						
1	338	963	471	325,576	159,198	166,378
2	1,212	1,212	631	1,468,917	764,772	704,145
3	1,592	2,236	721	3,559,788	1,147,832	2,411,956
4	1,419	2,036	891	2,888,690	1,264,329	1,624,361
5	147	2,297	1,014	337,587	149,058	188,529
6	1	1,016	1,168	1,016	1,168	(152)
7	267	2,506	1,407	669,095	375,669	293,426
8	8	1,855	1,376	14,839	11,008	3,831
9	0	NA	1,894	0	0	0
Totals	**4,984**			**$9,265,508**	**$3,873,034**	**$5,392,474**

Source: State Fund's medical bill review file and Medicare's ASC rates.

NA = Not applicable.